MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03300

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 2 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Moscow
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Ezekiel (Middle) ANdREW (Last) Ayers

4. DATE OF DEATH (Month) April (Day) 24 (Year) 1949

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower
8. DATE OF BIRTH Nov.5-1877
9. AGE last birthday 71 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner(retired)
10b. KIND OF BUSINESS OR INDUSTRY digging coal
11. BIRTHPLACE (State or foreign country) Barton Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Ayers
14. MOTHER'S MAIDEN NAME Jessie Meeks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Fred Ayers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
916.0 Immediate cause	(a) 2nd. & 3rd.degree burns, thorax & head	2 days
181 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Burned after house caught fire	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home (CITY OR TOWN) Moscow (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) 4-22/49 8A.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? House caught fire while he was asleep

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☒ origin (fire)*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED April 24- 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF April 26, 1949
NAME OF CEMETERY OR CREMATORY Laurel Hill
LOCATION (City, town, or county) Barton (State) Maryland

DATE REC'D BY LOCAL REG. Apr. 26/49
REGISTRAR'S SIGNATURE [illegible] M.D. Mrs. Nancy Rol[illegible]
24. FUNERAL DIRECTOR Ellsworth S. Boal ADDRESS Westernport Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
APR 28 1949
BUREAU T. S.

Within corporate limits: BALDWIN, U.W.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03301

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany County — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 18 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 239 Elder Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 239 Elder Street

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Wesley (Last) Baldwin

4. DATE OF DEATH: (Month) April (Day) 22 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 12/31/1869

9. AGE last birthday: 79 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): railroad trackman

10b. KIND OF BUSINESS OR INDUSTRY: R.R. Co.

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John W. Baldwin

14. MOTHER'S MAIDEN NAME: Isabella McKee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Joseph F. Baldwin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	12 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (422.1 93d)	(b) Chronic Myocarditis	5 yrs
	(c) Arteriosclerosis	10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) (COUNTY) (STATE): Cumberland Alleg. Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from Nov 15, 1946, to 4/22/49, 1949, that I last saw the deceased alive on 4/21/49 1949, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

SIGNATURE: R. Williams (Degree or title) M.D. ADDRESS: Cumberland Md. DATE SIGNED: 4/25/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 4/25/49

NAME OF CEMETERY OR CREMATORY: Abe Cemetery

LOCATION (City, town, or county) (State): Mineral County, W. Va.

DATE REC'D BY LOCAL REG.: April 25, 1949

REGISTRAR'S SIGNATURE: Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR: John C. Holford, ADDRESS: Cumberland Md

VS. A15

RECEIVED
MAY 3 1949
BUREAU V. S.

Within corporate limits

03302

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 317 Williams St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 317 Williams St.

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Edward (Last) Berry

4. DATE OF DEATH (Month) Apr (Day) 3 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 6/7/1872
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman
10b. KIND OF BUSINESS OR INDUSTRY Queen City Dairy
11. BIRTHPLACE (State or foreign country) Fort Ashby W. Va
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George Berry
14. MOTHER'S MAIDEN NAME Ellen Laing

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-4562
17. INFORMANT Ellen Berry

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uraemia — INTERVAL BETWEEN ONSET AND DEATH 3 wks

151

Antecedent cause(s)

46b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Stomach — 6 mo.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to Apr. 3, 1949, that I last saw the deceased alive on Apr. 2, 1949, and that death occurred at 4 a.m. m., from the causes and on the date stated above.

SIGNATURE Clay E. Durrett (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 4/5/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 4/5/49
NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery
LOCATION (City, town, or county) Fort Ashby, (State) W. Va.

DATE REC'D BY LOCAL REG. April 5, 1949
REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

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VS. A15

RECEIVED
APR 12 1949
BUREAU V. S.

Within corporate limits

DR. MURRAY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03303

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 6 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MT. SAVAGE
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) DERRELL	(Middle) F.	(Last) BLANK	4. DATE OF DEATH	(Month) APRIL (Day) 7 (Year) 1949
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH DEC. 16, 1945	9. AGE last birthday 3 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME CARL J. BLANK	14. MOTHER'S MAIDEN NAME MARY McKENZIE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

055 Immediate cause (a) Diphtheria — 9 days

10 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Tonsillar Pharyngeal S. Nasal

(c) Heart failure — immediate

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. M

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1949, to April 7, 1949, that I last saw the deceased alive on April 6, 1949, and that death occurred at 5 a.m., from the causes and on the date stated above.

SIGNATURE F. Alan G. Murray (Degree or title) W.D. — ADDRESS 41 Green St Cumberland Md — DATE SIGNED

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE THEREOF 4/8/49	NAME OF CEMETERY OR CREMATORY St Patrick	LOCATION (City, town, or county) (State) Mt Savage
DATE REC'D BY LOCAL REG. 4-7-49	REGISTRAR'S SIGNATURE Winter R Frantz M.D.	24. FUNERAL DIRECTOR J R Durst - Frostburg	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 12 1949
BUREAU V. S.

RECEIVED
APR 12 19[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

03304

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING — Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (in this place) 3 Months; HOSPITAL OR INSTITUTION OR STREET ADDRESS 259 Main St. Ext.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) 259 Main St. Ext.

3. NAME OF DECEASED (Type or Print): (First) Darius (Middle) Stanard (Last) Broadwater

4. DATE OF DEATH: (Month) April (Day) 22 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Jan. 15, 1949

9. AGE last birthday: yrs. If under 1 year: Months 3, Days 7, If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): XXX

10b. KIND OF BUSINESS OR INDUSTRY: XXX

11. BIRTHPLACE (State or foreign country): Maryland - Alleg.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Darius D. Broadwater

14. MOTHER'S MAIDEN NAME: Alice LaRue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): XXXX (If year, give war or dates of service): XXXX

16. SOCIAL SECURITY NO.: XXXX

17. INFORMANT: Alice LaRue

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Other Diseases Of The Heart Not Specified As Rheumatic. — Interval Between Onset and Death: Two Hours

470

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

115C

(b) Acute Nasopharyngitis — Two Days

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 20, 1949, to Apr. 22, 1949, that I last saw the deceased alive on Apr. 22, 1949, and that death occurred at 1:25 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Paul R. Wilson M.D. ADDRESS Piedmont W.Va. DATE SIGNED Apr. 23, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE April 23, 1949 — NAME OF CEMETERY OR CREMATORY: Philos Cem. — LOCATION (City, town, or county) (State): Westernport, Alle. Md.

DATE REC'D BY LOCAL REG. Apr. 23/49 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: Ellsworth S. Bogl — ADDRESS: Westernport, Md.

VS. A15

RECEIVED
APR 24 1949
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03305

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midlothian; LENGTH OF STAY (in this place) all his life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midlothian
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) (Last) BRODBECK

4. DATE OF DEATH: (Month) Apr. (Day) 29, (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 12-2-1865

9. AGE last birthday: 83 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): miner

10b. KIND OF BUSINESS OR INDUSTRY: coal mines

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Brodbeck

14. MOTHER'S MAIDEN NAME: Caroline Roche

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. George Brodbeck

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute cardiac congestive failure	2 weeks
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic heart disease	15 yrs?
	(c) Anthraco silicosis	?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death	Chr. Bronchitis + Emphysema + Bronchiectasis	15 yrs?

420.0
932

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/26, 1949, to 4/29, 1949, that I last saw the deceased alive on 4/29, 1949, and that death occurred at 8:00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Frank T. Harrat M.D. 59 E. Main St. Frostburg Md. 4/30/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 5-2-49 | NAME OF CEMETERY OR CREMATORY: Allegany Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 5-2-49 | REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: J. R. Durst, | ADDRESS: Frostburg, Md.

RECEIVED
MAY 4 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

03306

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 413 Pulaski St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 413 Pulaski St.

3. NAME OF DECEASED (Type or Print): (First) Bertha (Middle) Idella (Last) Browning

4. DATE OF DEATH: (Month) Apr. (Day) 18, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 5-23-1880

9. AGE last birthday: 68 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James O.S. Hinkle

14. MOTHER'S MAIDEN NAME: Susan V. Willison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Lester Browning

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260 Immediate cause (a) Cardiac Vascular

61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Renal Disease (Uremia)

(c) Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-28, 1946, to 4-18, 1949, that I last saw the deceased alive on 4-9, 1949, and that death occurred at 12:15 P. m., from the causes and on the date stated above.

SIGNATURE W. F. Williams (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 4-19-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 4-20-1949

NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: April 20, 1949

REGISTRAR'S SIGNATURE: Walter K. Bantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS Cumberland, Md.

RECEIVED
APR 21 1949
BUREAU V. S.

Within corporate limits.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03307

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 60 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 208 Union Street	STREET ADDRESS (If rural, give location): 208 Union Street

3. NAME OF DECEASED (Type or Print)	(First) Anna	(Middle) Mabel	(Last) Bucy	4. DATE OF DEATH	(Month) April	(Day) 20	(Year) 1949
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: Nov 5, 1885	9. AGE last birthday: 63 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House	10b. KIND OF BUSINESS OR INDUSTRY: House	11. BIRTHPLACE (State or foreign country): Lancaster County, Penna	12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME: John W. Lookabaugh	14. MOTHER'S MAIDEN NAME: Mary Houck						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Edgar Bucy					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
260 Immediate cause	(a) Acute Coronary Disease.	1 day.
61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes Mellitus.	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 19, 1949, to April 20, 1949, that I last saw the deceased alive on April 19, 1949, and that death occurred at Four A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
B. M. Schindler	M.D.	41 Greene St. Cumberland Md.	4/20/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: 4/23/49	NAME OF CEMETERY OR CREMATORY: St Marys Cemetery	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: April 22, 1949	REGISTRAR'S SIGNATURE: Winter R. Lantz, M.D.	24. FUNERAL DIRECTOR: William H. Kight	ADDRESS: Cumberland, Md.

RECEIVED
APR 26 1949
BUREAU U. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03308 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 46 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Queen City Brewing Co.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 539 Greenway Ave.

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) Henry (Last) Buskey
4. DATE OF DEATH (Month) April (Day) 11 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Dec. 18-1902
9. AGE last birthday 46 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Queen C. Brewing Co.
11. BIRTHPLACE (State or foreign country) (Narrows Park) Md. Cumberland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph G. Buskey
14. MOTHER'S MAIDEN NAME Catherine McDonald
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. (If yes, give war or dates of World War I + II
16. SOCIAL SECURITY NO. 714-10-5551
17. INFORMANT Mrs. Joseph Buskey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary occlusion	at once
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

Deputy Medical Examiner - Allegany Co.

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ 4-11, 1949, ~~to~~ ~~10~~, that I last saw the deceased ~~alive~~ Dead on 4-11, 1949, and that death occurred ~~at~~ about 8 Am.m., from the causes and on the date stated above.

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED April 11-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF April 13 '49
NAME OF CEMETERY OR CREMATORY Sts Peter + Pauls Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. April 12, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland Md

Deputy Medical Examiner - Allegany Co.

VS. A15

RECEIVED
APR 19 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03309

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 7 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners' Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural, give location) High Street

3. NAME OF DECEASED (Type or Print): (First) John Francis (Middle) (Last) Byrne

4. DATE OF DEATH: (Month) Apr. (Day) 21 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct 24 1883

9. AGE last birthday: 65 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Mining

10b. KIND OF BUSINESS OR INDUSTRY: Mining

11. BIRTHPLACE (State or foreign country): Ocean, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick Byrne

14. MOTHER'S MAIDEN NAME: Diana O'Bayne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

16. SOCIAL SECURITY NO.: 217-03-2163

17. INFORMANT: Alphonsus Byrne

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac Dilation & Congestive Failure

443

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

932

(b) Hypertension and Cardio Vascular disease

(c) & Auricular Fibrillation

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Miners Asthma

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1947, to 4/21, 1949, that I last saw the deceased alive on 4/20, 1949, and that death occurred at 5 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Paul Eugene Frye M.D. ADDRESS Lonaconing Md. DATE SIGNED 4/21/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE Apr. 23-49; NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery; LOCATION (City, town, or county) Lonaconing Allegany Co. (State) Md.

DATE REC'D BY LOCAL REG. 4-23-49; REGISTRAR'S SIGNATURE Mrs. Nancy N. Rae

24. FUNERAL DIRECTOR J. N. Eichhorn; ADDRESS Lonaconing Md.

RECEIVED
APR 26 1949
BUREAU V. S.

Within corporate limits

Evidence for change of birth date shown on p. 54

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03310

CERTIFICATE OF DEATH

FILM No. GD 1,2 D MAY 26 1949

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 25 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 164 N. Center St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 164 N. Center St.

3. NAME OF DECEASED (Type or Print): (First) HOLLAWAY (Middle) W. (Last) CAMPBELL

4. DATE OF DEATH: (Month) April (Day) 23, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 31, ~~1949~~ 1858

9. AGE last birthday: 90 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumber, Hotel, Merchantile

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Litchfield, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Burnett Campbell

14. MOTHER'S MAIDEN NAME: Clara Learcock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT: Harry Campbell, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 **Immediate cause** (a) Coronary Thrombosis

131a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c) Heart failure

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19~~46~~, to April, 19~~4~~9, that I last saw the deceased alive on April 18, 1949, and that death occurred at 5 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. Alan S. Marshall, M.D. 41 Bruce St. Cumberland, Md. April 25, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: April 25, 1949 | NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: April 25, 1949 | REGISTRAR'S SIGNATURE: Walter K. Lantz, M.D. | 24. FUNERAL DIRECTOR ADDRESS: William H. Kight Cumberland, Md.

RECEIVED
MAY 3 1949
BUREAU V. S.

Within corporate limits DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03311

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 7 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE WEST VIRGINIA COUNTY MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WILEY FORD
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) BABY BOY (Middle) (Last) CHUCCI

4. DATE OF DEATH (Month) APRIL (Day) 16 (Year) 1949

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 3:30 P.M. April 16, 1949

9. AGE last birthday yrs. | If under 1 year Months | Days | If under 24 hrs. Hours 7 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MEMORIAL HOSPITAL, CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME VANCE CHUCCI

14. MOTHER'S MAIDEN NAME BETTY LOU MATHEWS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intra Cranial Haemorrhage

760.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

1600 (b) (Breech Delivery)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 16, 1949, to Apr. 16, 1949, that I last saw the deceased alive on Apr. 16, 1949, and that death occurred at 9:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Clay J. Turner M.D. Cumberland 4/17/49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL

DATE THEREOF APRIL 19, 1949

NAME OF CEMETERY OR CREMATORY ABER Cem.

LOCATION (City, town, or county) (State) WILEY FORD, W.VA.

DATE REC'D BY LOCAL REG. APRIL 17, 1949

REGISTRAR'S SIGNATURE Wilbur K. Mantz, M.D.

24. FUNERAL DIRECTOR James J. Scarpelli ADDRESS Cumberland and

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APR 26 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03312

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 5 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Sisters of Providence

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Mt. Savage~~; STREET ADDRESS (If rural, give location) Midland, Md.

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) William (Last) Elise

4. DATE OF DEATH: (Month) 4 (Day) 15 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Child

8. DATE OF BIRTH: Dec. 18-1944

9. AGE last birthday: 4 yrs. If under 1 year: Months. 4 Days 3 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Frostburg Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Elmer A. Elise

14. MOTHER'S MAIDEN NAME: Nellie Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

(If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr Elmer Elise

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Encephalitis	7 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Measles	15 days
	(c)	

085.0

35

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-10, 1949, to 4-14, 1949, that I last saw the deceased alive on 4-14, 1949, and that death occurred at 8:15 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Adolf Wolkowicz	M.D.	Frostburg, Md	4-15-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 4-18-49

NAME OF CEMETERY OR CREMATORY: Allegany Co.

LOCATION (City, town, or county) (State): Frostburg Md

DATE REC'D BY LOCAL REG. 4-18-49

REGISTRAR'S SIGNATURE: Mrs Stanley K Roe

24. FUNERAL DIRECTOR: Daniel Davis

ADDRESS: Frostburg, Md

VS. A15

RECEIVED
APR 23 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03313

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 52 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 33 Arch Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 33 Arch St.

3. NAME OF DECEASED (Type or Print) Francis [redacted] (First) Earl (Middle) Constable (Last)

4. DATE OF DEATH (Month) April (Day) 24, (Year) 1949

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH July 26, 1894

9. AGE last birthday ~~55~~ 54 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman

10b. KIND OF BUSINESS OR INDUSTRY B&O R. R.

11. BIRTHPLACE (State or foreign country) Keyser W.Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John W. Constable

14. MOTHER'S MAIDEN NAME Minnie Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 705-10-0724

17. INFORMANT Wife same address

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 Immediate cause (a) Cerebral Hemorrhage

932 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive cardiovascular disease (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on 4-24, 1949 and that death occurred at 1:45 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John A. Dyer, M.D. ADDRESS 247 Virginia Ave. DATE SIGNED 4/25/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE April 27, 1949 NAME OF CEMETERY OR CREMATORY Rose Hill LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. April 25, 1949 REGISTRAR'S SIGNATURE Winnie L. Krantz, M.D.

24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland Md

RECEIVED
MAY 3 1949
BUREAU V. S.

03314

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Spring St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 62 Spring St.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Amelia (Last) Davis

4. DATE OF DEATH: (Month) Apr. (Day) 20 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 2-14-1861

9. AGE last birthday: 88 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel A. House

14. MOTHER'S MAIDEN NAME: Elizabeth O'Farrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Samuel Davis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Hemorrhage — Interval between onset and death: 10 Days

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension — many years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 10, 1949, to Apr 20, 1949, that I last saw the deceased alive on Apr 15, 1949, and that death occurred at 2:00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm C Lane MD — Frostburg Md — 4-21-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 4-23-49 | NAME OF CEMETERY OR CREMATORY: Allegany Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 4-23-49 | REGISTRAR'S SIGNATURE: Mrs Nancy A. Roe | 24. FUNERAL DIRECTOR: Joseph R. Diesel | ADDRESS

VS. A15

RECEIVED
APR 26 1949
BUREAU T. S.

Dr. Reeves

03315

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport — LENGTH OF STAY (in this place) 15 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
HOSPITAL OR INSTITUTION OR STREET ADDRESS 329 Md. Avenue	STREET ADDRESS (If rural, give location) 329 Md. Avenue

3. NAME OF DECEASED (Type or Print)	(First) Victoria	(Middle) Regina	(Last) Davis	4. DATE OF DEATH	(Month) April	(Day) 11	(Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Feb. 19, 1862	9. AGE last birthday 87 yrs.	If under 1 year Months. Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) xxx		10b. KIND OF BUSINESS OR INDUSTRY x xx	11. BIRTHPLACE (State or foreign country) Clarksburg, W.Va.			12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Carr			14. MOTHER'S MAIDEN NAME Jane Monday				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) xxx	(If year, give war or dates of service) xxxx	16. SOCIAL SECURITY NO. xxxx	17. INFORMANT Mrs. French Koontz				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause	(a) Bronchial pneumonia (terminal)	1 day
93d Antecedent cause(s)	(b) Myocardial insufficiency	10 days.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Chronic Myocarditis	1 mo.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1949, to April 11, 1949 that I last saw the deceased alive on 4/11, 1949, and that death occurred at 3 A.m., from the causes and on the date stated above.

SIGNATURE J Norman Reeves, M.D. (Degree or title) ADDRESS Westernport, Md DATE SIGNED 4/11/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE April, 13, 1949	NAME OF CEMETERY OR CREMATORY Philos Cem.	LOCATION (City, town, or county) (State) Westernport, Md.
DATE REC'D BY LOCAL REG. Apr. 11/49	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Ellsworth S. Boal	ADDRESS Westernport, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
APR 12 1949
BUREAU V. S.

DR. W.F. WILLIAMS.

Within corporate limits

03316

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY, STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give name of town) OR TOWN CUMBERLAND, MD.
LENGTH OF STAY (In this case) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND, COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WESTERNPORT
STREET ADDRESS (If rural, give location) 217 VINE ST.

3. NAME OF DECEASED (Type or Print): (First) FRANK (Middle) M. (Last) DAYTON

4. DATE OF DEATH: (Month) April (Day) 6, (Year) 1949

5. SEX M

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH DEC. 10, 1895

9. AGE Last birthday 53 yrs. If under 1 year Months Days; If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY GREAT AMER. TEA CO.

11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME HENRY DAYTON

14. MOTHER'S MAIDEN NAME EMMA DAWSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-7734

17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Coronary Thrombosis — Interval between onset and death: Hours

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) & Myocardial Infarction — 17-49.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 4, 1949, to April 6, 1949, that I last saw the deceased alive on 4-6-, 1949, and that death occurred at 3:25 p.m., from the causes and on the date stated above.

SIGNATURE W.F. Williams (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 4-7-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF April 10 1949 — NAME OF CEMETERY OR CREMATORY Phlox — LOCATION (City, town, or county) (State) Westernport, Md.

DATE RECD BY LOCAL REG. April 8, 1949 — REGISTRAR'S SIGNATURE Wm. K. Dantz, M.D.

24. FUNERAL DIRECTOR C.S. Boal — ADDRESS Westernport, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03317

CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing — LENGTH OF STAY (in this place) 42 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Big Vein Hill

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) Big Vein Hill

3. NAME OF DECEASED (Type or Print): (First) ALICE (Middle) — (Last) DONALD

4. DATE OF DEATH: (Month) Apr. (Day) 4 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: DEC 22 1886

9. AGE last birthday: 62 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Her Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Lee

14. MOTHER'S MAIDEN NAME: Ellen —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs John Cross

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	1 day
Antecedent cause(s)		
420.1 94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	5 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 4, 1949, to Apr 4, 1949, that I last saw the deceased alive on Apr 4, 1949, and that death occurred at 6 A m., from the causes and on the date stated above.

SIGNATURE: F E Berry (Degree or title) — ADDRESS: Piedmont W. Va. — DATE SIGNED: 4/4/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: April 6 '49 — NAME OF CEMETERY OR CREMATORY: Philos Cemetery — LOCATION (City, town, or county): Westernport (State): Md.

DATE REC'D BY LOCAL REG.: April 6 1949 — REGISTRAR'S SIGNATURE: Jannette M Cool

24. FUNERAL DIRECTOR: M. Eichhorn — ADDRESS: Lonaconing

RECEIVED
MAY 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03318 6

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresap Park, Cresaptown
LENGTH OF STAY (in this place) 20 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresap Park, Cresaptown Md.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Paul ~~A. Durr~~ (Middle) A (Last) Durr

4. DATE OF DEATH (Month) April (Day) 16 (Year) 1949

5. SEX male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH June 11-1912

9. AGE last birthday 36 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spiner at Celanese

10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.

11. BIRTHPLACE (State or foreign country) Thomas W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Adam Durr

14. MOTHER'S MAIDEN NAME Elizabeth Pase

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 2

16. SOCIAL SECURITY NO. 214-07-5352

17. INFORMANT wife) Helen Durr

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary Occlusion	at once
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	noticable about 2 weeks
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

Deputy Medical Examiner - Allegany Co.

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ 4-16, 1949, ~~to~~ ~~19~~, that I last saw the deceased Dead ~~alive~~ on April 16 1949, and that death occurred at 9.30 P. m., from the causes and on the date stated above.

SIGNATURE H.V. Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED April 16 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF April 1949

NAME OF CEMETERY OR CREMATORY Allegany Cemetery

LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REG. April 18, 1949

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR M. Elichhorn Lonaconing Md. ADDRESS

Deputy Medical Examiner - Allegany Co.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 22 1949
BUREAU V. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03319

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany Hospital MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 20 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7 Grand Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 7 Grand Ave.

3. NAME OF DECEASED (Type or Print) (First) James (Middle) ~~Henry~~ Henry (Last) Dyche

4. DATE OF DEATH (Month) (Day) (Year) April 21, 1949

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Oct. 21, 1861

9. AGE last birthday 87 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Forman

10b. KIND OF BUSINESS OR INDUSTRY W. M. R.R.

11. BIRTHPLACE (State or foreign country) Orleans, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George H. Dyche

14. MOTHER'S MAIDEN NAME Lucinda Ashkettle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Wife Same Address

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 Immediate cause (a) Left cerebral hemorrhage

93d Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive cardiovascular

(c) disease

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on Apr. 21, 1949, and that death occurred at 10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John A. Dyer, MD. 247 Virginia Ave.

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE April 25, 1949

NAME OF CEMETERY OR CREMATORY St Marys Cem.

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. April 22, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR James F. Scarselli

ADDRESS Cumberland Md

RECEIVED
APR 26 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS-A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

03320

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1454

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 8 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 329 Frederick St.	STREET ADDRESS (If rural, give location) 329 Frederick St.

3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) E.	(Last) EDMONSTON	4. DATE OF DEATH (Month) April (Day) 22, (Year) 1949	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 17, 1870	9. AGE last birthday 79 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel employee	10b. KIND OF BUSINESS OR INDUSTRY Hotel	11. BIRTHPLACE (State or foreign country) Hampshire Co. W. Va.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert Edmondson	14. MOTHER'S MAIDEN NAME Emily Edmondson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY No. 213 24 6878	17. INFORMANT Mrs. Alpharatta Smith			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Heart failure	1 week
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive and arteriosclerotic Heart Disease	5 years
	(c)	

420.0

93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION no	19b. MAJOR FINDINGS OF OPERATION no	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) no	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) no (CITY OR TOWN) (COUNTY) (STATE) no	
TIME OF INJURY (Month) (Day) (Year) (Hour) no m.	INJURY OCCURRED While at Work ☐ Not While At work ☐ no	HOW DID INJURY OCCUR? no

22. I hereby certify that I attended the deceased from June, 1948, to Apr 22, 1949, that I last saw the deceased alive on Apr 22, 1949, and that death occurred at 11 45 p.m., from the causes and on the date stated above.

SIGNATURE Saville Q Weisman mrs (Degree or title) ADDRESS 122 Bedford St, Cumberland, Md DATE SIGNED 4/23/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF April 26, 1949	NAME OF CEMETERY OR CREMATORY Sumner Cemetery	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. April 26, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR Wm. H. Kight, Cumberland, Md.	ADDRESS

RECEIVED
MAY 3 1949
BUREAU V. S.

03321

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Saint Mary's Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) St. Mary's Terrace

3. NAME OF DECEASED (Type or Print) (First) Thomas (Middle) James (Last) Elliott
4. DATE OF DEATH (Month) Apr (Day) 8 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH May 11, 1872
9. AGE last birthday 76 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Mining
10b. KIND OF BUSINESS OR INDUSTRY Coal Mine
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John B. Elliott
14. MOTHER'S MAIDEN NAME Savilla Shockey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 1
17. INFORMANT Mrs. David Douglas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hemorrhage from Gastric Ulcer — INTERVAL BETWEEN ONSET AND DEATH: 7 day

540.0 Antecedent cause(s)

112 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Bronchial Asthma

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1949, to Apr, 1949, that I last saw the deceased alive on Apr. 6, 1949, and that death occurred at 6:15 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Henry M. Hodgson M.D. ADDRESS R1 Cumberland Md DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE April 11, 49
NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
LOCATION (City, town, or county) (State) Lonaconing, Allegany Co., Md.

DATE REC'D BY LOCAL REG. April 12 1949
REGISTRAR'S SIGNATURE Jeannette M Boal
24. FUNERAL DIRECTOR M. Eichhorn, ADDRESS Lonaconing, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 3 1949
BUREAU V. S.

Within corporate limits.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03322

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp [redacted]

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 106 Robert St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Henrietta C. Engelbach

4. DATE OF DEATH (Month) (Day) (Year) April 26 1949 19

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Feb. 28, 1882
9. AGE last birthday 67 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Gallitzin, Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Peter O' Skelley
14. MOTHER'S MAIDEN NAME Susan Howell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

585 Immediate cause (a) Chronic Cholecystitis — INTERVAL BETWEEN ONSET AND DEATH 10 years

127a Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1939, to April 26, 1949, that I last saw the deceased alive on April 26, 1949, and that death occurred at 11:30 P. m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) M.D. ADDRESS Cumberland Md. DATE SIGNED April 28. 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE April 30, 1949
NAME OF CEMETERY OR CREMATORY St. Marys Cem.
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. April 28, 1949
REGISTRAR'S SIGNATURE Winter K. Lantz, M.D.
24. FUNERAL DIRECTOR James J. Scarpelli ADDRESS Cumberland, Md.

RECEIVED
MAY 3 1949
BUREAU P. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03323

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 5 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE West Virginia — COUNTY Hampshire; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Springfield; STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) EMORY (Middle) CLOYD (Last) EVANS

4. DATE OF DEATH: (Month) Apr. (Day) 28, (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: 6-24-1885

9. AGE last birthday: 63 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Tavern

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph W. Evans

14. MOTHER'S MAIDEN NAME: Harriet Lingenfelter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT: Joseph L. Evans

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Peritonitis	24 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Ruptured Intestine	at least 72 hrs.
	(c) Carcinoma — ?? — either prostatic or intestinal ??	

177
518

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: NONE

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NONE — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 27, 1949, to April 28, 1949, that I last saw the deceased alive on April 28, 1949, and that death occurred at 11:55 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Martin Rothstein M.D. 48 Broadway - Frostburg - Md 4/29/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE 4-30-49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 4-29-49 — REGISTRAR'S SIGNATURE: Mrs. Nancy A. Roe

24. FUNERAL DIRECTOR: J. R. Durst, — ADDRESS: Frostburg, Md.

RECEIVED
MAY 3 1949
BUREAU U. S.

Within corporate limits — DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03324

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 14 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 231 PEAR STREET

3. NAME OF DECEASED (Type or Print): (First) SARA (Middle) (Last) FATKIN

4. DATE OF DEATH: (Month) APRIL (Day) 11 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW

8. DATE OF BIRTH: 8/22-86

9. AGE last birthday: 62 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: JAMES WONN

14. MOTHER'S MAIDEN NAME: EMMA BENNETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443 Immediate cause (a) Myocardial Failure — 2 wks

932 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chr. Myocarditis — —

(c) Hypertension —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN): Cumberland — (COUNTY): Alleg — (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐: —

HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from Feb 25, 1949, to April 11, 1949, that I last saw the deceased alive on April 10, 1949, and that death occurred at 5 m., from the causes and on the date stated above.

SIGNATURE: [signature] — (Degree or title): M.D. — ADDRESS: Cumberland — DATE SIGNED: Md

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: April 13, 1949 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REG.: April 13, 1949 — REGISTRAR'S SIGNATURE: Walter L. Bantz, M.D. — 24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumb. Md

RECEIVED
APR 19 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03325

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1015 Gay St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1015 Gay St.

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Edward (Last) Goetz

4. DATE OF DEATH (Month) April (Day) 21 (Year) 1949

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH June 28/47

9. AGE last birthday 1-9mo.26d. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----

10b. KIND OF BUSINESS OR INDUSTRY -------

11. BIRTHPLACE (State or foreign country) Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William Francis Goetz

14. MOTHER'S MAIDEN NAME Julia Hazel Forbeck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. *

17. INFORMANT Mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
434.3 Immediate cause	(a) Anemia	?
95C. Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) malnutrition, hydrothorax, pulmonary edema (marked)	?
	(c) Cardiac hypertrophy	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

Deputy Medical Examiner - Allegany Co.

22. I hereby certify that I ~~attended~~ saw the deceased from April 22 1949, to ---------, 19--, that I last saw the deceased ~~alive~~ Dead on April 22, 1949, and that death occurred at 11.50P. m., from the causes and on the date stated above.

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED April 22-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Apr 23,49 NAME OF CEMETERY OR CREMATORY Mt Herman Cem LOCATION (City, town, or county) Rural Cumberland (State) Md

DATE REC'D BY LOCAL REG. April 22, 1949 REGISTRAR'S SIGNATURE Wrater R. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS " "

Deputy Medical Examiner - Allegany Co.

RECEIVED
APR 26 1949
BUREAU V. S.

Within corporate limits

03326

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, LENGTH OF STAY (in this place): 87 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 10 Market Street	STREET ADDRESS (If rural give location): 10 Market St.

3. NAME OF DECEASED (Type or Print) (First) Amanda	(Middle) Ann	(Last) Graham	4. DATE OF DEATH (Month) April	(Day) 6	(Year) 1949
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Sept 28, 1861	9. AGE last birthday: 87 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework	10b. KIND OF BUSINESS OR INDUSTRY: at home	11. BIRTHPLACE (State or foreign country): Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: James C. Christie		14. MOTHER'S MAIDEN NAME: Sarah Rebecca Jackson.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Edith Graham			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
260	Immediate cause	(a) Convulsions, Coma	3 days
61	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes	3 years
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Abdominal tumor — 10 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to April 6 1949, that I last saw the deceased alive on April 3, 1949, and that death occurred at 7:45 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
F. Alan G. Murray	M.D.	La Vale	Md

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: April 9, 1949	NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: April 7, 1949	REGISTRAR'S SIGNATURE: Winter R. Trautz, M.D.	24. FUNERAL DIRECTOR: John J. Hofer, Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 12 1949
BUREAU V. S.

Within corporate limits Dr. Ransom

03327

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural give location) 218 Glenn St

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) Boy (Last) Gray			4. DATE OF DEATH (Month) April (Day) 1 (Year) 1949		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Child	8. DATE OF BIRTH April 1, 1949	9. AGE last birthday yrs.	If under 1 year Months / Days; If under 24 hrs. Hours 4 Min. 10 mins
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Walter Gray			14. MOTHER'S MAIDEN NAME Dorothy Jean Swaner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY No. None	17. INFORMANT Walter Gray		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

776 Immediate cause (a) Previable Premature

Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 April, 1949, to 1 April, 1949, that I last saw the deceased alive on 1 April, 1949, and that death occurred at 8:30 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Leland B Ransom	MD	63 Greene St., Cumberland Md	1 April 49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	4/2/49	Hafer Crematorium	Cumberland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 2, 1949	Winter R. Frantz, M.D.	John J. Hafer	230 Balto Ave., Cumb., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 5 1949
BUREAU V. S.

Within corporate limits

03328

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

DR. HODGES

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE EVERETT, Pennsylvania COUNTY BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EVERETT
STREET ADDRESS (If rural, give location) Star Route

3. NAME OF DECEASED (Type or Print) (First) BABY (Middle) BOY HARCLERODE (Last)

4. DATE OF DEATH (Month) April (Day) 15 (Year) 1949

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH APRIL 15, 1949

9. AGE last birthday yrs. If under 1 year Months Days If under 24 hrs. Hours Min. 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cumberland Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME BRADY R HARCLERODE

14. MOTHER'S MAIDEN NAME VELMA F FOOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.0 157e

Immediate cause (a) Pulmonary stenosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Open interventricular septum

(c) Pulmonary atelectasis

INTERVAL BETWEEN ONSET AND DEATH: [redacted] 21 m.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 15, 1949, to April 15, 1949, that I last saw the deceased alive on April 15, 1949, and that death occurred at 8 L5 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. Royce Hodges, ADDRESS Cumberland, Md. DATE SIGNED 4/15/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF April 18/49

NAME OF CEMETERY OR CREMATORY Everett Cemetery

LOCATION (City, town, or county) Everett Pa. (State)

DATE REC'D BY LOCAL REG. April 17, 1949

REGISTRAR'S SIGNATURE W. R. Lantz, M.D.

24. FUNERAL DIRECTOR Stanley Gump ADDRESS Everett Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 26 1949
BUREAU T. S.

Within corporate limits

DR. R. WMS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03329

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 2 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): 516 VIRGINIA AVENUE

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JOHN	M	HENSELL	APRIL	26	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
MALE	WHITE	DIVORCED	NOV. 11 1880	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RESTAURANT OWNER	RESTAURANT OWNER	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
PETER HENSELL	ELIZABETH THOMAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Unk.			MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause	(a) Myocardial Failure	
94 a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Thrombosis	24 hrs
	(c) Arteriosclerosis Prostatic Enlargement	10 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Urinary retention in bladder

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
3/26/49	Cystotomy	Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
		Cumberland	Alley	Md

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
— m.		

22. I hereby certify that I attended the deceased from 2/15/49, 19....., to 4/26/49, 19....., that I last saw the deceased alive on 4/26/49, 19....., and that death occurred at 5 30 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
R. Williams		Cumberland, Md	4/27/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	April 29, 1949	Allegany Cemetery	Frostburg, Md.	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 28, 1949	Winter R. Frantz, M.D.	John J. Hofer, Cumberland, Md.	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
MAY 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

033305

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresap Park — LENGTH OF STAY (in this place) 1 day	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Stephen City
HOSPITAL OR INSTITUTION OR STREET ADDRESS Meadow View Drive	STREET ADDRESS (If rural, give location) Route 1.

3. NAME OF DECEASED (Type or Print)	(First) JAMES	(Middle) MONROE	(Last) HOUNSHELL	4. DATE OF DEATH	(Month) April (Day) 25, (Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 30, 1867	9. AGE last birthday 81 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Woodstock, Virginia	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Pearson Oliver Hounshell		14. MOTHER'S MAIDEN NAME Mary Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Edgar L. Hounshell			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary Occlusion — 1 hr

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 26 Apr., 1949, to 26 Apr., 1949, that I last saw the deceased alive on 26 Apr., 1949, and that death occurred at 19 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. T. Rees Now 404 Decatur St Cumberland Md 26 Apr 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF April 28, 1949	NAME OF CEMETERY OR CREMATORY Massanetten Cemetery	LOCATION (City, town, or county) (State) Woodstock, Va.
DATE REC'D BY LOCAL REG. April 27, 1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR William H. Kight	ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 5 1949
BUREAU

Within corporate limits: DR. MURRAY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03331

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 3 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CORRIGANSVILLE, MD.; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) RICHARD (Middle) W. (Last) HOWELL

4. DATE OF DEATH: (Month) APRIL (Day) 22, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: AUG. 28, 1933

9. AGE last birthday: 15 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: WALTER N. HOWELL

14. MOTHER'S MAIDEN NAME: LOIS DURST

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) (2) Aplastic Anaemia — Interval between onset and death: 5 months

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (1) Cerebral Hemorrhage — 12 hours

292.4 83a

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949 to April 22 1949, that I last saw the deceased alive on April 21, 1949, and that death occurred at 2 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Clay G. Shumaker M.D. ADDRESS: 14 Broadway, Cumberland, Md. DATE SIGNED: April 22 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: April 24, 1949

NAME OF CEMETERY OR CREMATORY: Fritzwater Cemetery

LOCATION (City, town or county) (State): Swanton, Garrett Co., Md.

DATE REC'D BY LOCAL REG.: April 24, 1949

REGISTRAR'S SIGNATURE: Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR: Harvey H. Zeigler, ADDRESS: Hyndman, Pa

VS. A15

RECEIVED
MAY 3 1949
BUREAU OF S.

Within corporate limits

Dr Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03332

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 45 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 2 Oals St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 2 Oals St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Timothy	Lucy	Howser	Apr	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hr.: Hours	Min.
Male	White	Widowed	Apr 18, 1864	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Boilermaker Helper	B & O R.R.	Oldtown Md.	U.S.

13. FATHER'S NAME: Soloman Howser
14. MOTHER'S MAIDEN NAME: Nancy Crabtree.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		None	Mrs Jessie Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.1 Immediate cause	(a) Coronary Thrombosis	Sudden
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	5 yrs
	(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Apr. 20, 1949, to Apr 20, 1949, that I last saw the deceased alive on Apr. 20, 1949, and that death occurred at 9:45 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Clay E. Jones	M D	Cumberland	4/21/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Apr 23, 1949	Hillcrest Cemetery	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 21, 1949	Winter R. Frantz, M.D.	John J. Hofer	Cumberland Md

VS. A15

RECEIVED
APR 26 1949
BUREAU V. S.

Within corporate limits DR DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

03333

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY ALLEGANY CUMBERLAND MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
LENGTH OF STAY (in this place) 12 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MARYLAND
STREET ADDRESS (If rural, give location) 31 HAWTHORNE AVENUE

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) B (Last) JAMES

4. DATE OF DEATH (Month) APRIL (Day) 20, (Year) 1949

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH AUG. 1 1870

9. AGE last birthday 78 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) W. VA.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME ELIJAH JAMES

14. MOTHER'S MAIDEN NAME ELIZABETH TROBRIDGE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153 Immediate cause (a) Carcinoma Colon — Interval between onset and death: ?

462 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinomatosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 4-13-49

19b. MAJOR FINDINGS OF OPERATION Carcinoma Colon

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-12-49, 19..., to 4-20, 19.49, that I last saw the deceased alive on 4-20-, 1949, and that death occurred at 7:25 P m., from the causes and on the date stated above.

SIGNATURE C. Zimmerman (Degree or title) ADDRESS DATE SIGNED 4-20-49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 4/22/49 | NAME OF CEMETERY OR CREMATORY Texas Cemetery | LOCATION (City, town, or county) (State) Horseshoe Run W. Va.

DATE REC'D BY LOCAL REG. April 22, 1949 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR Wayne C. Spiggle ADDRESS Davis, W. Va.

VS. A15

RECEIVED
APR 26 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03334

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 27 yrs.; MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Elmer (Middle) (Last) Jefferies

4. DATE OF DEATH: (Month) April (Day) 20 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: May 1-1899

9. AGE last birthday: 49 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): making bread & cake

10b. KIND OF BUSINESS OR INDUSTRY: Baker

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Jefferies

14. MOTHER'S MAIDEN NAME: Anna Stevens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ***** (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-01-6090

17. INFORMANT: Allegany Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion due to — Interval Between Onset and Death: at once

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary thrombosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I saw the deceased from 4-20, 19 49 to ----------, 19---, that I last saw the deceased alive on 4-20, 19 49 and that death occurred at 11 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland Md. April 20-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF April 23 1949

NAME OF CEMETERY OR CREMATORY Allegany Cemetary

LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REG. April 2-2, 1949

REGISTRAR'S SIGNATURE Arnter K. Hantz, M.D. Deputy Medical Examiner - Allegany Co.

24. FUNERAL DIRECTOR ADDRESS M. Eichhorn, Lonaconing Md.

VS. A15

RECEIVED
APR 26 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03335 V

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresaptown
LENGTH OF STAY (in this place) 38 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Winchester Rd

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresaptown
STREET ADDRESS (If rural, give location) Winchester Rd

3. NAME OF DECEASED (Type or Print): (First) James (Middle) William (Last) Kammann

4. DATE OF DEATH: (Month) Apr. (Day) 15 (Year) 1949

5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single — 8. DATE OF BIRTH: Oct 21 1896 — 9. AGE last birthday: 52 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter — 10b. KIND OF BUSINESS OR INDUSTRY: General — 11. BIRTHPLACE (State or foreign country): Eckhart Md — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Adam Kammann — 14. MOTHER'S MAIDEN NAME: Annie Ratigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service) World War I — 16. SOCIAL SECURITY NO. 214-17-3774 — 17. INFORMANT: John L. Kammann

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 **Immediate cause** (a) Acute coronary occlusion — 6 hours

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerotic heart disease — 2 years

(c) do

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-3, 1943, to 4-15, 1949, that I last saw the deceased alive on 4-10-, 1949, and that death occurred at 7 30 A m., from the causes and on the date stated above.

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED

L Kreiss — MD — 59 Greene St. Cumberland Md — 4-15-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Apr 18 '49 — NAME OF CEMETERY OR CREMATORY St Ambrose Cem — LOCATION (City, town, or county) (State) Cresaptown Md

DATE REC'D BY LOCAL REG. 4/18/49 — REGISTRAR'S SIGNATURE M L Townsend — 24. FUNERAL DIRECTOR — ADDRESS Louis Stein Inc Cumberland

RECEIVED
APR 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03336 9

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; MARYLAND; LENGTH OF STAY (in this place) 40 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 241 Welsh Hill

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 241 Welsh Hill

3. NAME OF DECEASED (Type or Print): (First) Lizzie (Middle) (Last) Kerns

4. DATE OF DEATH: (Month) 4 (Day) 7 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 6-21-1864

9. AGE last birthday: 84 yrs. If under 1 year: Months. 9 Days 16 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Old Town, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Hoover

14. MOTHER'S MAIDEN NAME: Mary Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT: Mr. George Kerns,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

180 **Immediate cause** (a) Carcinoma Left Kidney — 2 yrs

52a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) with General Metastasis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19..47, to April 7, 19..49, that I last saw the deceased alive on Apr 4, 19..49, and that death occurred at 900 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

W W McClane MD | Frostburg Md | Apr 8 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 4-10-1949 | NAME OF CEMETERY OR CREMATORY: Allegany Cem. | LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 4-8-49 | REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe | 24. FUNERAL DIRECTOR: Jacob Hafer | ADDRESS: Frostburg, Md

VS-A15

RECEIVED
APR 9 1949
BUREAU V. S.

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03337

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 13 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: MT. SAVAGE
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIAM	A.	KIRBY	April	2,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	WIDOWED	Feb. 10, 1865	84 yrs.	1	23		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none (retired)
10b. KIND OF BUSINESS OR INDUSTRY: Carpenter
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PHILLIP KIRBY
14. MOTHER'S MAIDEN NAME: SARAH METZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

590 Immediate cause (a) Senile debility,

139 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Suppression of Urine & Bronchopneumonia

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 2, 1949, to April 2, 1949, that I last saw the deceased alive on April 2, 1949, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE: J. R. Durst (Degree or title) ADDRESS DATE SIGNED: 4/3/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 4-5-49 | NAME OF CEMETERY OR CREMATORY: Methodist Cemetery | LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: April 4, 1949 | REGISTRAR'S SIGNATURE: Winter L. Lantz, M.D. | 24. FUNERAL DIRECTOR: J. R. Durst | ADDRESS: Frostburg, Md.

VS. A15

RECEIVED
APR 12 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

03338

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Corrigansville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Duane (Middle) L. (Last) Kline

4. DATE OF DEATH: (Month) April (Day) 29 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 5-11-1944

9. AGE last birthday: 4 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -------

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wilbur Leroy Kline

14. MOTHER'S MAIDEN NAME: Mary Alice Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: -------

17. INFORMANT: Hospital chart.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intracranial hemorrhage due to a rupture cerebral — about 10

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) of the middle ~~meningeal~~ artery — days.

(c) Fell about 4 Ft. & hit with a rock.

II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: home

(CITY OR TOWN): Corrigansville (COUNTY): Allegany (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): April ?/49 ? m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Fell about 4 Ft. & hit with a rock.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. — ADDRESS: H. V. Deming Md. Cumberland Md. — DATE SIGNED: April 29-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 5/2/49

NAME OF CEMETERY OR CREMATORY: Greenmount

LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR: May 2 1949

REGISTRAR'S SIGNATURE: Walter L. Bantz M.D.

24. FUNERAL DIRECTOR: Harvey H. Leigler — ADDRESS: Hyndman, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAY 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03339

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS 106 W. Main St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 106 W. Main St

3. NAME OF DECEASED (Type or Print): (First) George (Middle) William (Last) Krayer

4. DATE OF DEATH: (Month) 4 (Day) 5 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 12 1883

9. AGE last birthday: 65 yrs. If under 1 year: Months. 5 Days 13 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Frostburg Md

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Zacharias Krayer

14. MOTHER'S MAIDEN NAME: Sarah Lias

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

(If year, give war or dates of service)

16. SOCIAL SECURITY NO. 212-10-6236

17. INFORMANT: Miss Nellie Krayer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163

Immediate cause (a) Carcinoma Left Lung — Interval between onset and death: 2 yrs

H7d

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 14, 1949, to April 5, 1949, that I last saw the deceased alive on April 5, 1949, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Adam Lane M.D. Frostburg Md 4-6-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE 4-8-1949

NAME OF CEMETERY OR CREMATORY Allegany Cemetery

LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REG. 4-8-49

REGISTRAR'S SIGNATURE Mrs. Nancy R. Roe

24. FUNERAL DIRECTOR Jacob Hafer

ADDRESS Frostburg

RECEIVED
APR 9 1949
BUREAU V. S.

Within corporate limits DR. SIMONS

Evidence for change of birth date shown on:

FILM No. G 120 MAY 3 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03340

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 13 BROWNING STREET

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) W. (Last) LLOYD

4. DATE OF DEATH: (Month) APRIL (Day) 13. (Year) 19 49

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: MAY 23, 1887 (1888 struck)

9. AGE last birthday: 61 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: BOWLING ALLEY

11. BIRTHPLACE (State or foreign country): Clay County Ind.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WALTER LLOYD

14. MOTHER'S MAIDEN NAME: JANE KIDDY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

334 **Immediate cause** (a) Cerebro vascular Accident

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/11, 19 49, to 4/13, 19 49, that I last saw the deceased alive on 4/13, 19 49, and that death occurred at 8.03 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): George M. Simons M.D. — ADDRESS: 128 Arch St. Cumberland, Md. — DATE SIGNED: 4/13/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: April 16, 1949 — NAME OF CEMETERY OR CREMATORY: German Lutheran Cem. — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE RECD BY LOCAL REG.: April 14, 1949 — REGISTRAR'S SIGNATURE: Virgil K. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli Cumberland, Md.

RECEIVED
APR 19 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

1454 2411 N. Charles Street, Baltimore 03341

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Dr. Dick Williams

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 21 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 727 Shawnee Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 727 Shawnee Ave.

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) F (Last) LONG

4. DATE OF DEATH: (Month) April (Day) 9, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 22, 1884

9. AGE last birthday: 64 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: Kelly-Sp. Tire Co.

11. BIRTHPLACE (State or foreign country): Saltillo, Pa.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Geo. W. Long

14. MOTHER'S MAIDEN NAME: Elizabeth Querry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214 05 4584

17. INFORMANT: Mrs. Clara E. Long

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uremia — Interval Between Onset and Death: 10 years

422.2 / 131b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocarditis + chronic nephritis —

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death hut not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY: —

(CITY OR TOWN): Cumberland (COUNTY): Allegany (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Mar. 1, 19 49, to April 9, 19 49, that I last saw the deceased alive on 4/9/49 19, and that death occurred at 2 p. m., from the causes and on the date stated above.

SIGNATURE: R. H. Williams (Degree or title) M.D. ADDRESS: Cumberland Md. DATE SIGNED: 4/11/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: April 12, 1949

NAME OF CEMETERY OR CREMATORY: Cornelius Chapel Cemetery

LOCATION (City, town, or county) (State): Saltillo, Pa.

DATE REC'D BY LOCAL REG.: April 11, 1949

REGISTRAR'S SIGNATURE: Walter R. Lantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 19 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03342

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS La Vale.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) La Vale

3. NAME OF DECEASED (Type or Print) (First) Myrtle (Middle) A. (Last) Long

4. DATE OF DEATH (Month) Apr. (Day) 13 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Oct 10 1875
9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Bedford Valley, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Martin L. Dicken
14. MOTHER'S MAIDEN NAME Malinda Curley.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None.
17. INFORMANT W. Donald Long.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute myocardial failure Coronary sclerosis Pulmonary edema Angina like symptom	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) (Senility) Chronic cholecystitis	6 mo
	(c) Hypertension c̄ Coronary sclerosis (6/3/49-9.5)	3 yrs

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to April 13, 1949, that I last saw the deceased alive on April 13, 1949, and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Cyrle R. Everhart M.D. 36 Greene St Cumberland, Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Apr 16 '49
NAME OF CEMETERY OR CREMATORY Rose Hill Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. April 16, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
APR 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03343

CERTIFICATE OF DEATH

Reg. Dist. No. 14

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ellerslie
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ellerslie
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Maggie (Middle) (Last) Lowery

4. DATE OF DEATH: (Month) April (Day) 2 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Apr. 11 1861

9. AGE last birthday: 88 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Buffalo Mills, Pa.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Brant

14. MOTHER'S MAIDEN NAME: Catherine Brant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: Elmer Lowery Ellerslie Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.2 **Immediate cause** (a) Chronic Myocardosis — 15 yrs.

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1937, to Apr 2, 1949, that I last saw the deceased alive on April 2, 1949, and that death occurred at 6 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John A Topper — ADDRESS: Hyndman Pa — DATE SIGNED: Apr 3-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 4/ 5/1949 — NAME OF CEMETERY OR CREMATORY: Dry Ridge cemetery — LOCATION (City, town, or county) (State): Manns Choice Rd#1 Pa.

DATE REC'D BY LOCAL REG.: April 5th 1949 — REGISTRAR'S SIGNATURE: J Lloyd Wolfe

24. FUNERAL DIRECTOR: Harvey A. Legler — ADDRESS: Hyndman, Pa.

RECEIVED
MAY 2 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03344

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1101 Anderson St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1101 Anderson St.

3. NAME OF DECEASED (Type or Print) (First) Frank (Middle) J. (Last) Lueck

4. DATE OF DEATH (Month) April (Day) 7 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH May 4 1877
9. AGE last birthday 76 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman
10b. KIND OF BUSINESS OR INDUSTRY Railway
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lawrence Lueck
14. MOTHER'S MAIDEN NAME Bertha Schultz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 705-09-9637
17. INFORMANT Ann M. Lueck

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
334	Immediate cause	(a) Cerebro-Vascular Accident	8 hrs
83a	Antecedent cause(s)		
	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1947, to April, 1947, that I last saw the deceased alive on April 5, 1949, and that death occurred at 11:10 A.m., from the causes and on the date stated above.

SIGNATURE George M Simons (Degree or title) M.D. ADDRESS 128 Union St. DATE SIGNED 4/7/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Apr 9 49
NAME OF CEMETERY OR CREMATORY St Peter & Pauls Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. April 9, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

T

RECEIVED
APR 12 1949
BUREAU V. S.

Within corporate limits DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

03346

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (In this place) 43 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.VA COUNTY MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RIDGLEY
STREET ADDRESS (If rural, give location) KNOBLEY RD.

3. NAME OF DECEASED (Type or Print) (First) ROBERT (Middle) P. (Last) MAGRUDER
4. DATE OF DEATH (Month) APRIL (Day) 14 (Year) 1949

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH Sept. 3 1863
9. AGE last birthday 85 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR OF GAS STATION
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) ~~SEPT 3~~ W.VA
12. CITIZEN OF WHAT COUNTRY? AMERICA

13. FATHER'S NAME ~~MAGRUDER~~ Seton Magruder
14. MOTHER'S MAIDEN NAME Ruth Garl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr George Magruder

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	5 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	20 yrs
	(c) —	

422.1
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 2/15/49, 19....., to 4/14/49, 19....., that I last saw the deceased alive on 4/14/49, 19....., and that death occurred at 9 a.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
[signature] MD Cumberland Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4-16-49
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) (State) Cumberland - Md

DATE REC'D BY LOCAL REG. April 16, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George - Cumberland, Md. ADDRESS George

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

T

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APR 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03345

CERTIFICATE OF DEATH

Reg. Dist. No. 5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) Mch. 6. 1949
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cresap Park. TOWN

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick
STREET ADDRESS (If rural, give location) 4 East 3rd St

3. NAME OF DECEASED (Type or Print): (First) Allen (Middle) None McHenry (Last)

4. DATE OF DEATH: (Month) Apr (Day) 17 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: Feb 15-1869

9. AGE last birthday: 80 yrs. — If under 1 year: Months. 3 Days 2 — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Live Stock

11. BIRTHPLACE (State or foreign country): Frederick, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry (None) McHenry

14. MOTHER'S MAIDEN NAME: Katherine S. Crouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-22-1682

17. INFORMANT: Son - Ralph McHenry.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

161 Immediate cause (a) Carcinoma of the Larynx (In-operable) — Interval Between Onset and Death: 4 Mo

470 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) None

(c) None - Known

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) NO

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: X — (CITY OR TOWN) X (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) X m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 2, 1949, to Apr 17, 1949, that I last saw the deceased alive on Apr 17, 1949, and that death occurred at 6:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) L B Mathews M.D. — ADDRESS 49 Greene St Cumberland, Md. — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE 4-20-49 — NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery — LOCATION (City, town, or county) (State) Frederick - Md.

DATE RECD BY LOCAL REG. April 17, 1949 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR — ADDRESS C. E. Cline & Son - Frederick - Md.

RECEIVED
APR 22 1949
BUREAU V. S.

Within corporate limits

M

Durrett

03347

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 333 Dorn Ave.

3. NAME OF DECEASED (Type or Print) (First): Mary (Middle): Alice (Last): Metz

4. DATE OF DEATH (Month) (Day) (Year): April 27 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 16, 1879
9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Flintstone Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Thompson
14. MOTHER'S MAIDEN NAME: Laura Robinette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT: Mrs Evelyn Mason

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

260 Immediate cause (a) Chronic Myocarditis — 6 mos

61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diabetes Mellitus — 6 mos

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 1, 1949, to Apr. 27, 1949, that I last saw the deceased alive on Apr. 27, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE: Alan G. Durrett — (Degree or title): M.D. — ADDRESS: Cumberland — DATE SIGNED: 4/29/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Apr 30, 1949 — NAME OF CEMETERY OR CREMATORY: Zion Memorial Cem. — LOCATION (City, town, or county): Cumberland (State): Md

DATE REC'D BY LOCAL REG.: April 30, 1949 — REGISTRAR'S SIGNATURE: Winter R. Lantz M.D. — 24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

RECEIVED
MAY 3 1949
BUREAU V. S.

Dr Bennett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03348

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.F.D. #1, Frostburg, Md.; STREET ADDRESS (If rural give location) Gilmore

3. NAME OF DECEASED (Type or Print): (First) Catherine (Middle) (Last) Nicholls

4. DATE OF DEATH: (Month) April (Day) 30 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 20, 1908

9. AGE last birthday: 41 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Gilmore, Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Sarah Rennie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: William Rennie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

214 Immediate cause (a) Hemorrhage uterus resulting from

Antecedent cause(s)

56b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) submucous fibroid

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 4-30-49

19b. MAJOR FINDINGS OF OPERATION: Submucous Fibroid & Hemorrhage

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23 Apr., 1949, to 30 Apr., 1949, that I last saw the deceased alive on 30 Apr., 1949, and that death occurred at 12 45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John B. Davis, MD Frostburg, Md. 5/1/49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial; DATE: 5-3-49; NAME OF CEMETERY OR CREMATORY: Laurel Hill Cem.; LOCATION (City, town, or county) (State): Luzerne, Alleg. Md.

DATE REC'D BY LOCAL REG.: 5-1-49; REGISTRAR'S SIGNATURE: Mrs. Nancy V. Roe

24. FUNERAL DIRECTOR: E. S. Boal, Westernport, Md. ADDRESS

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MAY 4 1949
BUREAU V. S.

Within corporate limits

Dr. W.F. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03349

CERTIFICATE OF DEATH

Reg. Dist. No. 4

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital Cumberland, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: West Virginia, COUNTY: Hardy
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Moorefield
STREET ADDRESS (If rural, give location): Memorial Avenue, ✓

3. NAME OF DECEASED (Type or Print): (First) Loyd (Middle) George (Last) Miley

4. DATE OF DEATH: (Month) 4- (Day) 18 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Separated

8. DATE OF BIRTH: May 30, 1903

9. AGE last birthday: 45 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: General Farming

11. BIRTHPLACE (State or foreign country): Moorefield, West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Miley, George

14. MOTHER'S MAIDEN NAME: Godlove, Tressie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0 Immediate cause (a) Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH: Unknown

124 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-11, 1949, to 4-18, 1949, that I last saw the deceased alive on 4-17, 1949, and that death occurred at 5:20 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W.F. Williams M.D. Cumberland 4-18-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 20, 1949	Christ Cemetery	Moorefield W Va

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 18, 1949	Walter L. Kantz, M.D.	Earl B. Thrush	Moorefield W Va

VS. A15

RECEIVED
APR 26 1949
BUREAU V. S.

Within corporate limits DR. W. F. WILLIAMS

Evidence for change of arrangement in # 18 is on:

FILM No. G 120 JUN -6 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03350

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (In this place) 5 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN OLDTOWN, MD.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) BERTHA (Middle) V. (Last) MILLER

4. DATE OF DEATH (Month) APRIL (Day) 9, (Year) 1949

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH DEC. 10, 1879

9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME JOHN C. CUSTER

14. MOTHER'S MAIDEN NAME ANNIE E. AMBROSE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) (b) Chronic Myocardial Degeneration

61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) II Diabetes Mellitus

(c) (a) Broncho Pneumonia - Terminal [6/6/49 atm]

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3.27, 1949, to 4.9., 1949, that I last saw the deceased alive on 4.8., 1949, and that death occurred at 6 a m., from the causes and on the date stated above.

SIGNATURE W. F. Williams (Degree or title) ADDRESS Cumberland DATE SIGNED 4.9.49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 4/12/49

NAME OF CEMETERY OR CREMATORY Greenway Cem.

LOCATION (City, town, or county) (State) Berkley Springs, W. Va.

DATE REC'D BY LOCAL REG. April 12, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

(Signature)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 19 1949
BUREAU V. S.

Within corporate limits

03351

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 35 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 801 Fayette St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 801 Fayette St.

3. NAME OF DECEASED (Type or Print): (First) Eugene (Middle) Barbee (Last) Miller

4. DATE OF DEATH: (Month) April (Day) 22 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: Aug. 24. 1864

9. AGE last birthday: 84 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Master car builder (ret'd)

10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry

11. BIRTHPLACE (State or foreign country): Luray Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Miller

14. MOTHER'S MAIDEN NAME: Frances Virginia Barbee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Daughter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	11 yrs.
450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) arteriosclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: INJURY OCCURRED While at Work ☐ Not While At work ☐: HOW DID INJURY OCCUR?

Deputy Medical Examiner - Allegany Co.

22. I hereby certify that I attended the deceased from April 22 19.49, to ----------, 19--, that I last saw the deceased alive on April 22 19.49, and that death occurred about * 7 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.		Cumberland Md.	April 22- 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY, OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Apr 25 1949	Rose Hill Cem	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 25, 1949	Winter R. Tanty, M.D.	Louis Stein Sue	Cumberland Md

Deputy Medical Examiner - Allegany Co.

RECEIVED
APR 28 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

03352

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (in this place):	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 146 N.Mechanic St.	STREET ADDRESS (If rural, give location): 146 N.Mechanic

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Frank	Ruble	Moles	April	14	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	divorced	April 27.1900	48 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer	Cumberland Brew. Co.	Knoxville Tenn.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jerry Moles	Emily Jane Russell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	214-07-0109	Papers found in his room.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary occlusion	at once
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

Deputy Medical Examiner - Allegany Co.

22. I hereby certify that I ~~attended~~ saw the deceased from April 14 19 49, to ~~19~~, that I last saw the deceased alive on 4-14, 19 49 and that death occurred at about 6.30 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.		Cumberland Md.	April 14-1949

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, Town, or county)	(State)
Burial	Apr 18,1949	Knoxville Cem.	Knoxville	Tennessee

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 16, 1949	M.R. Fantz, M.D.	John J Hafer	Cumberland Md

Deputy Medical Examiner - Allegany Co.

VS. A15

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APR 19 1949
BUREAU V. S.

Dr. Raymond Reeves

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03353

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St. Extended

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) Main St. Extended

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Lee (Last) Moon

4. DATE OF DEATH: (Month) April (Day) 9 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 21, 1864

9. AGE last birthday: 84 yrs. | If under 1 year: Months. Days. | If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Schuyler Moon

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): XXXX
(If year, give war or dates of service): XXXX

16. SOCIAL SECURITY NO.:

17. INFORMANT: Sarah Moon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

442 Immediate cause (a) Chr. Cardio-Vascular-Renal Disease

131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/1, 1949, to 4/9, 1949, that I last saw the deceased alive on 4/9, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Raymond Reeves (Degree or title) MD ADDRESS Keelersport Md DATE SIGNED 4/10/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE April 12, 1949 | NAME OF CEMETERY OR CREMATORY Philos cem. | LOCATION (City, town, or county) Westernport | (State) Md.

DATE REC'D BY LOCAL REG. 4/10.11/49 | REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR Ellsworth S. Boal | ADDRESS Westernport Md.

RECEIVED
APR 12 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

03354

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 11 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barton
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Osborne		Moore	April	28	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Aug. 17- 1908	40 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bulldozer operator	Strip mining	Barton Md,	U.S.A.

13. FATHER'S NAME: Stanley Moore
14. MOTHER'S MAIDEN NAME: Virginia Imes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
Yes	W.W. 2		Anna Moore (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
910.3 Immediate cause	(a) Intracranial hemorrhage due to a stellate	13 hours
186 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) fracture of the skull, anterior & middle fossae	
	(c) Tree fell & struck him on the head.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	near Barton	Barton	Allegany	Md.

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☒	Not while at work ☐	HOW DID INJURY OCCUR?
April	27	49-	2.30 P.m.			Operating a bulldozer, tree fell on his head.

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D.	H.V. Deming M.D.	Cumberland Md.	April 28-1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	April 30, 1949	Laurel Hill Cemetery	Moscow,	Maryland

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 29, 1949	Hunter R. Hantz, M.D.	E.S. Boals	Westernport Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAY 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03355

Reg. Dist. No. 10

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage — LENGTH OF STAY (in this place): 40 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Upper New Row	STREET ADDRESS (If rural, give location): Upper New Row

3. NAME OF DECEASED (Type or Print)	(First) WILLIAM	(Middle) THOMAS	(Last) MULLAN	4. DATE OF DEATH (Month) April (Day) 24, (Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Aug. 4, 1875	9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad engineer	10b. KIND OF BUSINESS OR INDUSTRY: C. & P. RR	11. BIRTHPLACE (State or foreign country): Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William T. Mullan		14. MOTHER'S MAIDEN NAME: Anna Carlos		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Mr. Eugene Mullan		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

592	Immediate cause	(a) Myocarditis	4 to 5 years
131b	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Nephritis	5 years
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-16, 1949, to 4-24, 1949, that I last saw the deceased alive on 4-24, 1949, and that death occurred at 11:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William E. Moseley M. D. April 25th 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: April 27, 1949	NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery	LOCATION (City, town, or county) (State): Mt. Savage, Md.
DATE REC'D BY LOCAL REG.: April 26, 1949	REGISTRAR'S SIGNATURE: Veronica McDermott	24. FUNERAL DIRECTOR: William H. Kight	ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MAY 3 1949
BUREAU V. S.

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

03356

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

T

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 22 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 731 Columbia Ave.

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) E. (Last) Nightingale

4. DATE OF DEATH: (Month) April (Day) 23 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: June 23-1866

9. AGE last birthday: 82 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Gardner

14. MOTHER'S MAIDEN NAME: Martha Nicholson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Allegany Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Lobar pneumonia	about 24 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) chronic myocarditis & pulmonary edema	?
	(c)	

422.2
108

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D.	H.V. Deming M.D.	Cumberland Md.	April 23-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burr.	April 27th	Rose Hill Cem.	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 25, 1949	Walter L. Bantz, M.D.	Louis Stein & Co.	Cumberland Md

RECEIVED
MAY 3 1949
BUREAU V. S.

Within corporate limits

E. Brings

03357

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany	STREET ADDRESS (If rural, give location) 313 Avirett Ave.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Elizabeth Northcraft

4. DATE OF DEATH (Month) (Day) (Year): Apr. 12, 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: ~~4-12-49~~ 8-23-1872

9. AGE last birthday: 76 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Accident, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Hoffman

14. MOTHER'S MAIDEN NAME: Anna **********.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Harry Turley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
443 Immediate cause	(a) cerebral hemorrhage	2 weeks
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) hypertensive heart disease	years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 3, 1949, to April 12, 1949, that I last saw the deceased alive on April 11, 1949, and that death occurred at 12 15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Elizabeth Brings — ADDRESS La Vale, Md. — DATE SIGNED 4/13/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 4-14-49 — NAME OF CEMETERY OR CREMATORY: ST. Pauls Luthern Cem. — LOCATION (City, town, or county) (State): Accident, Md.

DATE REC'D BY LOCAL REG.: April 14, 1949 — REGISTRAR'S SIGNATURE: W. R. Frantz, M.D.

24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 19 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

03358

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 65 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Windsor Hotel

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Windsor Hotel

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	W.	Oss	April	25	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	Widowed.	4-23-1876	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter or janitor
10b. KIND OF BUSINESS OR INDUSTRY: Theater
11. BIRTHPLACE (State or foreign country): Wellersburg Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Oss
14. MOTHER'S MAIDEN NAME: Martha Moomagh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 220-10-8774
17. INFORMANT: Harry S. Oss

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c) Arteriosclerosis & hypertention	?

450.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.		Cumberland Md.	April 25-1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/28/49	Zion Memorial Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 28, 1949	Winter R. Fantz, M.D.	Charles L. George	Cumberland, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15A

RECEIVED
MAY 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03359

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing — LENGTH OF STAY (In this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rockville, Lonaconing, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) Rockville St. Lonaconing,

3. NAME OF DECEASED (Type or Print): (First) Wm. (Middle) Meredith (Last) Patton

4. DATE OF DEATH: (Month) Apr. (Day) 22nd (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: June 29 1886

9. AGE last birthday: 62 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer

10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Patton

14. MOTHER'S MAIDEN NAME: Euphemia Chalmers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes

16. SOCIAL SECURITY NO. (If year, give war or dates of service): World War I

17. INFORMANT: Mrs. Bessie Eilbeck

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 — 94a

Immediate cause (a) Coronary Occlusion —

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Embolism

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/22, 1949, to 4/22, 1949, that I last saw the deceased alive on 4/22, 1949, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul Eugene Frye M.D — Lonaconing Md — 4/23/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE Apr 25, 49 — NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery — LOCATION (City, town, or county) Lonaconing — (State) Md

DATE REC'D BY LOCAL REG. 4/26/49 — REGISTRAR'S SIGNATURE Jeanette M Boal — 24. FUNERAL DIRECTOR H. Eichhorn — ADDRESS Lonaconing Md.

VS. A15

RECEIVED
MAY 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03360

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vale Summit
LENGTH OF STAY (in this place) 37 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route No 1 Box 354

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vale Summit, Frostburg
STREET ADDRESS (If rural, give location) Box 354 Route 1

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Edward (Last) Phillips

4. DATE OF DEATH (Month) 4 (Day) 14 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Aug 3-1878-70
9. AGE last birthday 71 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY General
11. BIRTHPLACE (State or foreign country) Westernport, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT John E. Phillips

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

447 Immediate cause (a) Gangrene - both feet - peripheral circulatory failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks at least

97 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Stokes Adams Syndrome — 6 mos.

(c) Generalized Arteriosclerosis and Hypertension — years ??

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION NONE
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) NONE
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓ (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) ✓ m.
INJURY OCCURRED While at Work ☐ Not While At work ☐ ✓
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from NOVEMBER, 1948, to APRIL, 1949, that I last saw the deceased alive on APRIL 10, 1949, and that death occurred at 1:00 A.m., from the causes and on the date stated above.

SIGNATURE Martin W. Rothstein M.D. (Degree or title) ADDRESS 48 Broadway - Frostburg DATE SIGNED 4/19/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 4-16-49
NAME OF CEMETERY OR CREMATORY Lovair Cemetery
LOCATION (City, town, or county) Lane's Mt. Allegany (State) Md.

DATE REC'D BY LOCAL REG. 4-18-49
REGISTRAR'S SIGNATURE Mrs. Harvey H. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 23 1949
BUREAU U. S.

Within corporate limits Brings

03361

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 207 Hay St.

3. NAME OF DECEASED (Type or Print) (First): Gardner (Middle): Henry (Last): Piper

4. DATE OF DEATH (Month): Apr (Day): 10 (Year): 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Mar 4, 1874
9. AGE last birthday: 75 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: General farming
11. BIRTHPLACE (State or foreign country): Brunswick Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Piper
14. MOTHER'S MAIDEN NAME: Mary Groves.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Chester King

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

334 Immediate cause (a) cerebral arteriosclerosis — 4 days

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Apoplectic stroke — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-7-, 1949, to 4-10-, 1949, that I last saw the deceased alive on 4-9-, 1949, and that death occurred at 10 A m., from the causes and on the date stated above.

SIGNATURE: L Brings (Degree or title) MD — ADDRESS: 59 Greene St. Cumberland Md — DATE SIGNED: 4-12-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 4/14/49 — NAME OF CEMETERY OR CREMATORY: Allegany County Cemetery — LOCATION (City, town, or county): Cumberland (State): Md.

DATE REC'D BY LOCAL REG.: April 14, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: John J. Hofer — ADDRESS: Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 19 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03362

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) John (Middle) [illegible] (Last) Pirillo

4. DATE OF DEATH: (Month) April (Day) 19 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): >

8. DATE OF BIRTH: 7-7-72

9. AGE last birthday: 76 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: W.P.A.

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: >

17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
434.3	Immediate cause	(a) Cardiac failure due to	At once
92a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardiac hypertrophy(marked) aortic stenosis emphysema (marked) hydrothorax and ascites	?
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

Deputy Medical Examiner - Allegany Co.

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ April 19 1949, ~~to~~ ----------, 19--, that I last saw the deceased alive on 4-19, 19 49 and that death occurred at 6-45 P. m., from the causes and on the date stated above.

Dead

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D.	H. V. Deming M.D.	Cumberland Md.	April 19/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	April 23,1949	Allegany County Cemetery	Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 22, 1949	W.K. Lantz, M.D.	William H. Kight	Cumberland, Md.

Deputy Medical Examiner - Allegany Co.

VS. A15

RECEIVED
APR 26 1949
BUREAU V. S.

Evidence for addition in #18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03363

FILM No. G 120 MAY 25 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 9

The correct age

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners' Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) Jackson Street

3. NAME OF DECEASED (Type or Print): (First) Harriet (Middle) Ellen (Last) Pollard

4. DATE OF DEATH: (Month) April (Day) 14 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 26 1879 — 9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Dye

14. MOTHER'S MAIDEN NAME: Mary Ellen Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Anna May Metz

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

155 **Immediate cause** (a) Carcinoma of Liver C

46f **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) metastasis

(c) Carcinoma Primary in liver. 5/24/49 dms.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 apr, 1949, to 14 Apr, 1949, that I last saw the deceased alive on 14 apr, 1949 and that death occurred at 5:55 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

John B. Davis M.D. — Frostburg, Md. — 4/15/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: April 17 '49 — NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery — LOCATION (City, town, or county) (State): Moscow, Md

DATE REC'D BY LOCAL REG. 4-15-49 — REGISTRAR'S SIGNATURE: Ella Hawley V. Poe

24. FUNERAL DIRECTOR — ADDRESS: M. Eichhorn, Lonaconing Md.

RECEIVED
APR 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03364 Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 68 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 35 Mill St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 35 Mill St.

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Raphael (Last) Rafferty

4. DATE OF DEATH (Month) 4 (Day) 13 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 14-1879
9. AGE last birthday 70 yrs. If under 1 year: Months 2, Days 14; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draymans
10b. KIND OF BUSINESS OR INDUSTRY Express
11. BIRTHPLACE (State or foreign country) Mesopotamia Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Patrick Rafferty
14. MOTHER'S MAIDEN NAME Elizabeth Rafferty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs Charles Rafferty

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

196 Immediate cause (a) uremia

45d Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of mandible c̄

(c) metastasis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Jan, 1949, to 13 Apr, 1949 that I last saw the deceased alive on 13 Apr, 1949, and that death occurred at 11 ~~AM~~ P.M. m., from the causes and on the date stated above.

SIGNATURE John B. Davis, MD (Degree or title) ADDRESS Frostburg, Md DATE SIGNED 4/14/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 4-18-1949
NAME OF CEMETERY OR CREMATORY St. Michael's Cem.
LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REG. 4-15--49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Naffer ADDRESS Frostburg Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 19 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

03365

Reg. Dist. No. 4

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: En route to Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Midland
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lydia	Jean	Reeves	April	27	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	white	Single	May30-1947	23 mo yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	-----	Cumberland Md.	U.S.A.

13. FATHER'S NAME: Gerald Reeves

14. MOTHER'S MAIDEN NAME: Lydia Bradburn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	----------	Mr. Gerald Reeves - Father

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
334 Immediate cause	(a) Subarachnoid hemorrhage	?
830 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic choriditis	about 9 months
	(c) Cerebral edema	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Convulsions — about 9 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V.Deming M.D.		Cumberland Md.	April 28-1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Apr. 30, 1949	Hillcrest Cemetery	Near Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 28, 1949	Walter L. Fantz, M.D.	M. Eichhorn, Lonaconing, Maryland.	

VS. A15A

RECEIVED
MAY 3 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03366

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany — STATE Maryland
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 773 Maryland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 773 Maryland Ave.

3. NAME OF DECEASED (Type or Print) (First) Hanson (Middle) (Last) Rice

4. DATE OF DEATH (Month) April (Day) 19 (Year) 1949

5. SEX male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Dec 1st 1867

9. AGE last birthday 81 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman Retired

10b. KIND OF BUSINESS OR INDUSTRY Railway

11. BIRTHPLACE (State or foreign country) Allegany Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Rice

14. MOTHER'S MAIDEN NAME Sarah —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Elizabeth Spearman Rice (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151 Immediate cause (a) Carcinoma of Stomach — Interval Between Onset and Death: ?

46 b Antecedent cause (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1947, to April 19, 1949, that I last saw the deceased alive on April 18, 1949, and that death occurred at 7.45 A m., from the causes and on the date stated above.

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED
T Bailey Hunter MD — Cumberland Md — 4/19/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF April 21 '49 — NAME OF CEMETERY OR CREMATORY Hillcrest Cem. — LOCATION (City, town, or county) Cumberland — (State) Md

DATE RECD BY LOCAL REG. April 20, 1949 — REGISTRAR'S SIGNATURE Wm K. Lantz, M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc — ADDRESS Cumberland Md

VS-A15

RECEIVED
APR 26 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03367

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland, Rural
LENGTH OF STAY (In this place): 35 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route 2, ~~Cumberland, Md.~~

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland Rural
STREET ADDRESS (If rural give location): Route 2, Baltimore Pike

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Eva (Last) Rinehart

4. DATE OF DEATH: (Month) April (Day) 1 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 21 1895

9. AGE last birthday: 53 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: House

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: James Williams

14. MOTHER'S MAIDEN NAME: Annie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT: Mrs Charles Knippenberg

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153 Immediate cause (a) Carcinomatosis

462 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 2/26/46

19b. MAJOR FINDINGS OF OPERATION: Adenocarcinoma of sigmoid.

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) Cumberland (COUNTY) (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED Whiie at Work ☐ Not Whiie At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/26, 19 46, to April 2, 19 49, that I last saw the deceased alive on April 2, 19 49 and that death occurred at 11-30 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

4/3/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: April 4 1949

NAME OF CEMETERY OR CREMATORY: St Micheals Cemetery

LOCATION (City, town, or county) (State): Frostburg, Maryland

DATE REC'D BY LOCAL REG.: April 3, 1949

REGISTRAR'S SIGNATURE: Winter R. Bantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight, ADDRESS: Cumberland, Md.

RECEIVED
APR 12 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03368

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 411 S. Cedar St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 411 So. Cedar Street

3. NAME OF DECEASED (Type or Print): (First) Clem James (Middle) Henry (Last) Robinette

4. DATE OF DEATH: (Month) (Day) (Year) Apr. 1, 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec. 8, 1880

9. AGE last birthday: 68 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Tire Co.

11. BIRTHPLACE (State or foreign country): Paw Paw, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Dennis Robinette

14. MOTHER'S MAIDEN NAME: Anna McDonald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-07-1014

17. INFORMANT: Mr. Joseph Robinette

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary Thrombosis — Acute

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Sclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 1, 1949, to Apr. 1, 1949, that I last saw the deceased alive on Apr. 1, 1949, and that death occurred at 8:30 P. m., from the causes and on the date stated above.

SIGNATURE Clay E. Lantz (Degree or title) M. D. ADDRESS Cumberland DATE SIGNED 4/2/49.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 4-4-1949 | NAME OF CEMETERY OR CREMATORY: St. Mary's | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. April 3, 1949 | REGISTRAR'S SIGNATURE Winters K. Lantz, M.D. | 24. FUNERAL DIRECTOR: Charles L. George | ADDRESS: Cumberland, Md.

VS-A15

RECEIVED
APR 12 1949
BUREAU V. S.

Within corporate limits

Dr. R. Williams
Steel sign and Stamp
of Penna Life Ins. Co.

MARYLAND STATE DEPARTMENT OF HEALTH

03369

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS: A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland.
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 920 Maryland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 920 Maryland Ave.

3. NAME OF DECEASED (Type or Print): (First) Delia (Middle) (Last) Robinette

4. DATE OF DEATH: (Month) Apr. (Day) 27, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 4-1-1884

9. AGE last birthday: 65 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Thomas L. Keech

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 **Immediate cause** (a) Cerebral hemorrhage — Interval between onset and death: 48 hrs

932 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Precrin cerebral hemorrhage — 6 mo

(c) Hypertension Arteriosclerotic CVD — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) Cumberland (COUNTY) Alley (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/15/46, 19..... to 4/27/49, 19....., that I last saw the deceased alive on 4/24/49, 19....., and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE: B. Williams (Degree or title) ADDRESS: Cumberland Md DATE SIGNED: 4/29/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 4-30-1949

NAME OF CEMETERY OR CREMATORY: St. Patricks

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE RECD BY LOCAL REG.: April 30, 1949

REGISTRAR'S SIGNATURE: Winter K. Frantz M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

Mr George

RECEIVED
MAY 3 1949
BUREAU V. S.

Within corporate limits

Van Ormer

03370

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 58 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 804 Kentucky Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 804 Kentucky Ave.

3. NAME OF DECEASED (Type or Print) (First) Isa (Middle) Victoria (Last) Rowley

4. DATE OF DEATH (Month) Apr (Day) 5 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Jan 25, 1878
9. AGE last birthday 71 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Hampshire Co - W. Va
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME Hamilton Mitchell
14. MOTHER'S MAIDEN NAME Virginia Haines

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs Chester Collins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443
93d

Immediate cause (a) Cardiac arrest.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive heart disease with complete A-V block — 3 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) -Cumberland-----Allegany----Maryland
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1946, to April 5, 1949, that I last saw the deceased alive on April 2, 1949, and that death occurred at 2:00 P.m., from the causes and on the date stated above.

SIGNATURE W. Alfred Van Ormer (Degree or title) M.D. ADDRESS 531 Louisiana Ave. Cumberland, Md. DATE SIGNED April 6, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Apr 8, 1949
NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. April 7, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
APR 12 1949
BUREAU V. S.

Within corporate limit.

DR. FAW

03371

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 6 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 206 BEDFORD STREET

3. NAME OF DECEASED (Type or Print)	(First) JAMES	(Middle) JOSEPH	(Last) RYLAND	4. DATE OF DEATH	(Month) APRIL	(Day) 12	(Year) 1949
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH APRIL 10 1883	9. AGE last birthday 66 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELLER- LIBERTY TRUST BANK	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES RYLAND		14. MOTHER'S MAIDEN NAME BRIDGED DOBSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 214-05-6621	17. INFORMANT MEMORIAL HOSPITAL	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Embolism	Immediate
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Sub dural hematoma - left hemiplegia	mar 12, 1949
	(c) Head injury with depressed skull fracture	Jan 15, 1949

903.5
186a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION April 6, 1949	19b. MAJOR FINDINGS OF OPERATION Subdural hematoma right, extensive	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) accident	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street Bedford St.	(CITY OR TOWN) Cumberland	(COUNTY) Allegany	(STATE) Md.
TIME OF INJURY (Month) Jan (Day) 15 (Year) 1949 (Hour) 11:30 P.M.	INJURY OCCURRED While at Work ☐ Not While At work ☒	HOW DID INJURY OCCUR? Slipped, accidentally fell		

22. I hereby certify that I attended the deceased from Apr 5, 1949, to April 12, 1949, that I last saw the deceased alive on April 12, 1949, and that death occurred at 4:30 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wylie M Faw Jr.		5 Washington St. Cumberland Md	4-12-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF April 13 49	NAME OF CEMETERY OR CREMATORY St Patricks Cem	LOCATION (City, town, or county) Cumberland	(State) Md
DATE REC'D BY LOCAL REG. April 12, 1949	REGISTRAR'S SIGNATURE Winter L. Frantz, M.D.	24. FUNERAL DIRECTOR Louis Stein Inc	ADDRESS Cumberland	

RECEIVED
APR 19 1949
BUREAU V. S.

Within corporate limits

Durrett

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03372

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oldtown Md
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital	STREET ADDRESS (If rural give location) Route #1

3. NAME OF DECEASED (Type or Print) (First) Delcie (Middle) Bell (Last) Shryock	4. DATE OF DEATH (Month) Apr (Day) 6 (Year) 1949
5. SEX Female — 6. COLOR OR RACE White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 3, 1904 — 9. AGE last birthday 44 yrs. — If under 1 year Months Days — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework — 10b. KIND OF BUSINESS OR INDUSTRY at Home	11. BIRTHPLACE (State or foreign country) Oldtown Md — 12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John W. Buser	14. MOTHER'S MAIDEN NAME Delcie Bell Boggs
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs Virginia Hartley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

175 Immediate cause (a) Carcinomatosis from — 6 mon

49a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma Left Ovary

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Mar. 28. 1949	19b. MAJOR FINDINGS OF OPERATION Carcinomatosis	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 25, 1949, to Apr. 6, 1949, that I last saw the deceased alive on Apr. 6, 1949, and that death occurred at 6:10 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Clay E. Durrett	M. D.	Cumberland	4/7/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Apr 10, 1949	NAME OF CEMETERY OR CREMATORY Shryock Cemetery	LOCATION (City, town, or county) (State) Near Oldtown Md
DATE REC'D BY LOCAL REG. April 7, 1949	REGISTRAR'S SIGNATURE Arnter R. Frantz M.D.	24. FUNERAL DIRECTOR John J Hafer - Cumberland	ADDRESS Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

RECEIVED
APR 12 1949
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03373

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 713 Fayette St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 713 Fayette St.

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) Willard (Last) Smith

4. DATE OF DEATH: (Month) Apr (Day) 5 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 29, 1888

9. AGE last birthday: 60 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Frantz

14. MOTHER'S MAIDEN NAME: Laura Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs George Kemp "

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
420.1	Immediate cause	(a) Acute coronary occlusion	3 hrs.
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive vascular disease	10 years
		(c) Coronary heart disease	10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1949, to April 5, 1949, that I last saw the deceased alive on April 5, 1949, and that death occurred at 7:15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. Alfred Vance M.D. 531 Louisiana Ave., Cumberland, Md. April 6, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Apr 8, 1949	Greenmount Cemetery	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 7, 1949	Walter R. Frantz, M.D.	John J. Hafer	Cumberland Md

RECEIVED
APR 12 1949
BUREAU V. S.

Within corporate limits Durrett

03374

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md. — LENGTH OF STAY (in this place) 2 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Maryland
STREET ADDRESS (If rural, give location) 3 Miltonberg, R[redacted] Place

3. NAME OF DECEASED (Type or Print) (First) Jacob (Middle) L. (Last) Snyder
4. DATE OF DEATH (Month) April (Day) 8, (Year) 1949
5. SEX M
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower
8. DATE OF BIRTH Dec. 29, 1879
9. AGE last birthday 69 yrs. — If under 1 year Months Days — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.
11. BIRTHPLACE (State or foreign country) ~~Unknown~~ Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Joseph Snyder
14. MOTHER'S MAIDEN NAME Sarah Evans
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 705-09-9982
17. INFORMANT Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis — 6 mos

592 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Nephritis — 6 mos

131a (c) Uraemia

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 1, 1949, to Apr 8, 1949, that I last saw the deceased alive on Apr. 8, 1949, and that death occurred at 5:25 P m., from the causes and on the date stated above.

SIGNATURE Clay J. Durrett (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 4/9/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF April 11, 1949 — NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park — LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. April 11, 1949 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR John J. Hofer — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 19 1949
BUREAU V. S.

Within corporate limits DR. ENFIELD

Dr Cooper

03375

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
STREET ADDRESS (If rural, give location) REAR 72 WINEOW STREET

3. NAME OF DECEASED (Type or Print) (First) BESSIE (Middle) R. (Last) SPICER
4. DATE OF DEATH (Month) APRIL (Day) 26, (Year) 1949
5. SEX female
6. COLOR OR RACE COLORED
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SEPARATED
8. DATE OF BIRTH 1/11/1897
9. AGE last birthday 52 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ROBERT LEE CLARK
14. MOTHER'S MAIDEN NAME CORRINA — Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary metastasis	approx
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of cervix-uterine	2 years.
	(c)	

171
48a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 Apr., 1949, to 26 Apr., 1949, that I last saw the deceased alive on 25 Apr., 1949, and that death occurred at 1 30 a.m., from the causes and on the date stated above.

SIGNATURE L. S. Cooper. (Degree or title) M. D. ADDRESS 101 S. Centre St. Cumberland Md. DATE SIGNED 26 Apr. 49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF April 28, 1949
NAME OF CEMETERY OR CREMATORY Wood Lawn Cemetery
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. April 27, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 3 1949
BUREAU V. S.

Within corporate limits

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03376

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 7 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FROSTBURG,
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) HOSPITAL ROAD

3. NAME OF DECEASED (Type or Print)	(First) IRENE	(Middle) G.	(Last) STEINLA	4. DATE OF DEATH	(Month) APRIL	(Day) 21	(Year) 1949
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH MAY 20, 1894	9. AGE last birthday 54 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES GOLDSWORTHY			14. MOTHER'S MAIDEN NAME GUNTER, MARGARET				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ~~or unknown~~) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	3 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Abdominal Perineal Resection	
	(c) Carcinoma of rectum	

154
46d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. BP 170/110

19a. DATE OF OPERATION April 16-49	19b. MAJOR FINDINGS OF OPERATION Carcinoma of rectum	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 15, 1949, to April 21, 1949, that I last saw the deceased alive on April 20, 1949, and that death occurred at 3.55a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
S. E. Enfield		Cumberland	4/22/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4/24/49	NAME OF CEMETERY OR CREMATORY Allegany	LOCATION (City, town, or county) Frostburg, Md. (State)
DATE REC'D BY LOCAL REG. April 22, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR Ellsworth S. Boal	ADDRESS Westernport, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 26 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03377

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Frost Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 14 Frost Ave.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Marshall (Last) Stewart

4. DATE OF DEATH: (Month) April (Day) 14 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Nov. 18. 1893

9. AGE last birthday: 55 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): District Mgr. for Potomic Edison Co.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Midlothian Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Marshall Stewart

14. MOTHER'S MAIDEN NAME: Agnes Williamson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-10-4697

17. INFORMANT: Mrs. Fred Boettner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Exsanguination & cerebral hemorrhage — Interval Between Onset and Death: about 3 minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Shooting himself by putting muzzle of a shotgun

(c) in his mouth. (12 guage)

976

164 C

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Despondent, ill health.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE: suicide

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

(CITY OR TOWN): Frostburg (COUNTY): Allegany (STATE): Md.

TIME OF INJURY (Month) 4 (Day) 14/49 (Year) (Hour) about 1 P. m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Shot himself with a shotgun.

Deputy Medical Examiner - Allegany

22. I hereby certify that I attended the deceased from 4.14, 19 49 to ---------, 19--, that I last saw the deceased alive on April 14, 19 49 and that death occurred at about * 1 P. m., from the causes and on the date stated above.

SIGNATURE: H.V. Deming M.D. H.V. Deming M.D. (Degree or title) ADDRESS: Cumberland Md. DATE SIGNED: April 14/49

23. BURIAL, CREMATION / REMOVAL (Specify): Burial DATE THEREOF: 4/16/49 NAME OF CEMETERY OR CREMATORY: Allegany Cemetery LOCATION (City, town, or county): Frostburg (State): Md.

DATE REC'D BY LOCAL REG. 4-15-49 REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: Jacob Hafer ADDRESS: Frostburg, Md.

Deputy Medical Examiner - Allegany

VS. A15

RECEIVED
APR 19 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03378

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 4 1/2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 35 Offutt Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 35 Offutt Street

3. NAME OF DECEASED (Type or Print) (First) George (Middle) E. (Last) Sturtz

4. DATE OF DEATH (Month) April (Day) 6 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 22 1872
9. AGE last birthday 76 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Solomon Sturtz
14. MOTHER'S MAIDEN NAME Rebecca Albright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) No
16. SOCIAL SECURITY NO. —
17. INFORMANT Mrs. Margaret Young Sturtz

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 Immediate cause (a) Chronic Nephritis & Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1-2 years

131a Antecedent cause(s) (b) Generalized Arteriosclerosis — several years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) None m.
INJURY OCCURRED While at Work ☐ Not While At work ☐ None
HOW DID INJURY OCCUR? No injury

22. I hereby certify that I attended the deceased from Sept. 6, 1947, to April 5, 1949, that I last saw the deceased alive on April 5, 1949, and that death occurred at 3:15 P. m., from the causes and on the date stated above.

SIGNATURE B. M. Schindler (Degree or title) M.D. ADDRESS 41 Greene St., Cumberland, Md. DATE SIGNED 4/7/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE April 9 '49
NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
LOCATION (City, town, or county) Lonaconing (State) Md

DATE REC'D BY LOCAL REG. April 7, 1949
REGISTRAR'S SIGNATURE Winter K. Lantz, M.D.
24. FUNERAL DIRECTOR M. Eichhorn, ADDRESS Lonaconing Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
APR 12 1949
BUREAU V. S.

FILM No. G 120 JUN 15 1949

EVIDENCE FOR CHANGE OF AGE IS ON!

FILM No. G 120 MAY 23 1949

Dr. Jas. Wolverton Jr.

03379

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport — LENGTH OF STAY (in this place): 10 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 84 Main St.	STREET ADDRESS (If rural, give location): 84 Main St.

3. NAME OF DECEASED (Type or Print): (First) John Joseph (Middle) Thomas (Last)

4. DATE OF DEATH: (Month) April (Day) 5 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 27, 1895

9. AGE last birthday: 58 ~~54~~ yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stewart

10b. KIND OF BUSINESS OR INDUSTRY: K of C

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Thomas

14. MOTHER'S MAIDEN NAME: Fannie Swartz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service): W.W.I

16. SOCIAL SECURITY No.: 220-10-1093

17. INFORMANT: Mrs. Elizabeth Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	1 day
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Coronary Heart Disease	Undetermined

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 8, 1949, to April 5, 1949, that I last saw the deceased alive on April 5, 1949, and that death occurred at 2:00 P m., from the causes and on the date stated above.

SIGNATURE: James H Wolverton Jr MD (Degree or title) ADDRESS: 20 Green St Piedmont, W.Va. DATE SIGNED: April 7, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: April 8 1949 — NAME OF CEMETERY OR CREMATORY: St Peter's — LOCATION (City, town, or county): Westernport (State): Maryland

DATE REC'D BY LOCAL REG.: Apr. 7, 1949 — REGISTRAR'S SIGNATURE: [illegible] MD

24. FUNERAL DIRECTOR: Ellsworth S. Boal — ADDRESS: Westernport, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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APR 8 1949
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Evidence for change of age and first name shown on:

FILM No. G 120 APR 26 1949

03380

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 60 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 37 First Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 37 Frost Ave

3. NAME OF DECEASED (Type or Print) (First) Neenah (Middle) Dodge (Last) Townsend

4. DATE OF DEATH (Month) 4 (Day) 11 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Aug 18-1859
9. AGE last birthday 89 ~~90~~ yrs. If under 1 year: Months 7, Days 23; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) George Town D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Perley Dodge
14. MOTHER'S MAIDEN NAME Caroline R. Neath

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Eugene Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 Immediate cause (a) Arterio Sclerosis — Interval Between Onset and Death: Several years

59b Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Chronic arthritis — many years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1940, 19..., to Apr 11, 1949, that I last saw the deceased alive on Apr 9, 1949, and that death occurred at 11 00 A m., from the causes and on the date stated above.

SIGNATURE W. O. McLane (Degree or title) MD ADDRESS Frostburg Md DATE SIGNED 4-12-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Apr. 13-1949
NAME OF CEMETERY OR CREMATORY Allegany Cem.
LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. 4-13-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 18 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

03381

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 412 Grand Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 412 Grand Ave.

3. NAME OF DECEASED (Type or Print): (First) MINNIE (Middle) BELLE (Last) TURNER

4. DATE OF DEATH: (Month) April (Day) 7, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: April 2, 1876

9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days / Hours / Mln. — If under 24 hrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hardy Co. W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Christian Bensenhaver

14. MOTHER'S MAIDEN NAME: Nancy Weese

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Ethel Cornell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerosis Cardio-Vascular Renal — 2 yrs

420.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocarditis

(c) Gangrene Left Foot

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 15, 1949 to Apr. 7, 1949, that I last saw the deceased alive on Apr 6, 1949, and that death occurred at 11:30 P m. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Clark Turner M. D. Cumberland 4/8/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: April 10, 1949 — NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery — LOCATION (City, town, or county) (State): Arthur, W. Va.

DATE RECD BY LOCAL REG.: April 8, 1949 — REGISTRAR'S SIGNATURE: Winter R. Bantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Earl. B. Thrush, Moorefield, W. Va.

VS. A15

RECEIVED
APR 12 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03382

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Co. Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 232 W. Beech St. Allegany Co. Infirmary

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Rebecca (Last) Wells

4. DATE OF DEATH: (Month) April (Day) 19 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 12/22/1859

9. AGE last birthday: 89 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Wise

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Raymond B. Wells

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial failure — 3 days

422.2 / 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Chronic myocarditis — 6 yrs
(c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1946, to Apr. 19, 1949, that I last saw the deceased alive on Apr. 16, 1949, and that death occurred at 5-00 p.m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones — (Degree or title) M.D. — ADDRESS: 110 S. Centre St. — DATE SIGNED: Apr. 22, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 4/22/49 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: April 22, 1949 — REGISTRAR'S SIGNATURE: W. K. Kantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer Cumberland Md

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RECEIVED
APR 26 1949
BUREAU V. S.

Within corporate limits

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03383

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 43 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 520 Holland St.

3. NAME OF DECEASED (Type or Print) (First) ANNA (Middle) MILLER (Last) WELSH

4. DATE OF DEATH (Month) April (Day) 10, (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH June 3, 1871

9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Buffalo Mills, Pa.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Abraham M. Miller

14. MOTHER'S MAIDEN NAME Anna Marie Nicodemus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT Mrs. J. F. Zimmerman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

260 Immediate cause (a) Coronary occlusion — 4 days

61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) coronary sclerosis — a. 12 hours

(c) diabetes mellitus

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1942, to April 10, 1949, that I last saw the deceased alive on April 10, 1949, and that death occurred at 3 30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Elizabeth Brings

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF April 13 1949

NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. April 15, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

RECEIVED
APR 19 1949
BUREAU V. S.

Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 218 S. Smallwood St.

3. NAME OF DECEASED (Type or Print) (First) Frank (Middle) Wayman (Last) White

4. DATE OF DEATH (Month) April (Day) 9 (Year) 1949

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Unknown

8. DATE OF BIRTH ?

9. AGE last birthday 80 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Unknown

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 220-10-2600

17. INFORMANT Allegany Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) generalized arteriosclerosis	5 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic heart disease	4 years
	(c)	

420.0
93d

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. gangrene of left lower leg — 4 months

19a. DATE OF OPERATION 2-28-49

19b. MAJOR FINDINGS OF OPERATION marked sclerotic changes of femoral artery

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-28, 1949, to 4-9-, 1949, that I last saw the deceased alive on 4-8-, 1949, and that death occurred at 3 A m., from the causes and on the date stated above.

SIGNATURE L Brings (Degree or title) MD ADDRESS 59 Greene St. Cumberland Md DATE SIGNED 4-12-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF April 14, 1949

NAME OF CEMETERY OR CREMATORY Allegany County Cemetery

LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. April 14, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hofer ADDRESS Cumberland, Md.

RECEIVED
APR 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03385

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 16 Hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midlothian
STREET ADDRESS (If rural, give location) Near Frostburg

3. NAME OF DECEASED (Type or Print) (First) Maybell (Middle) (Last) Whitehead
4. DATE OF DEATH (Month) April (Day) 5 (Year) 1949
5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 5-13-1897
9. AGE last birthday 51 yrs. If under 1 year Months 10 Days 22 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY housewife
11. BIRTHPLACE (State or foreign country) Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Blocher
14. MOTHER'S MAIDEN NAME Louise Garlitz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT John Whitehead

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) 2nd. & 3rd degree burns, of body, from neck to knees 17 hrs.

916.0
181

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Kerosene can exploded, while trying to start a fire in kitchen stove.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
(CITY OR TOWN) Midlothian (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) April 5/49 4.45 A.m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? Kerosene can exploded.

22. I hereby certify that I attended the deceased from 4-5, 1949, to ------, that I last saw the deceased Dead on 4.5, 1949, and that death occurred at 10.40 P.m., from the causes and on the date stated above.

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED 4-6-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4-8-1949
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg, Md. (State) Md.
DATE REC'D BY LOCAL REG. 4-8-49
REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

Deputy Medical Examiner - Allegany Co

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03386

Reg. Dist. No. 9

EVIDENCE FOR CHANGE OF AGE IS ON: FILM No. G 120 MAY 23 1949

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 1 day; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 26 Hill St

3. NAME OF DECEASED (Type or Print): (First) Benjamin (Middle) D. (Last) Williams

4. DATE OF DEATH: (Month) 4 (Day) 23 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 6-3-1881

9. AGE last birthday: 67 ~~68~~ yrs. If under 1 year: Months. 10 Days 20 Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Shaft Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): Spanish American

16. SOCIAL SECURITY No.: 215-18-8672

17. INFORMANT: Mrs George Rees

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary ~~thrombosis~~ occlusion	15 minutes
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	years
	(c) ~~Tumor of lung~~	

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypernephroma (?)

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to April 23 1949, that I last saw the deceased alive on 4-23, 1949, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) L. Wolfenman M.D. | ADDRESS Frostburg, Md | DATE SIGNED 4-25-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 4-26-49 | NAME OF CEMETERY OR CREMATORY Eckhart Cemetery | LOCATION (City, town, or county) (State) Eckhart, Allegany, Md.

DATE REC'D BY LOCAL REG. 4-25-49 | REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe | 24. FUNERAL DIRECTOR ADDRESS Jacob Naylor Frostburg, Md.

VS. A15

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APR 27 1949
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Within corporate limits

03387

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 67 Greene St.

3. NAME OF DECEASED (Type or Print) (First) Frederick (Middle) Carl (Last) Williams
4. DATE OF DEATH (Month) Apr. (Day) 6, (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 10-15-1908
9. AGE last birthday 40 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Corp. Preparation Dept.
10b. KIND OF BUSINESS OR INDUSTRY Silk
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Henry B. Williams
14. MOTHER'S MAIDEN NAME Melissa D. Schilling
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-07-1514
17. INFORMANT Henry B. Williams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) apoplectic insult	2 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arterial hypertension	3 years
	(c) chronic nephritis	4 years

592
131b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-1-, 1948, to 4-6-, 1949, that I last saw the deceased alive on 4-5-, 1949, and that death occurred at 3 AM m., from the causes and on the date stated above.

SIGNATURE L Brings (Degree or title) MD ADDRESS 59 Greene St. Cumberland Md DATE SIGNED 4-7-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4-8-1949
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. April 8, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03388

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; MARYLAND; LENGTH OF STAY (in this place) 6 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 113 Walnut St.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Ernest (Last) Williams

4. DATE OF DEATH: (Month) 4 (Day) 21 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 6-4-1903

9. AGE last birthday: 45 yrs. If under 1 year: Months 10; If under 24 hrs.: Days 17; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY: Fuller S. Co

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James E. Williams

14. MOTHER'S MAIDEN NAME: Gael Boettner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):

16. (If year, give war or dates of service) SOCIAL SECURITY NO.: 214-07-0307

17. INFORMANT: Mrs Geo. E. Williams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral embolus / Acute Congestive Cardiac failure	Instant / 10 d.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Rheumatic valvulitis + Carditis (Hx)	38 yrs.
	(c) secondary anemia	2 mo ±

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Internal Hemorrhoids (bleeding) — 3 mo ±

414
92 c

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/15, 1949, to 4/20, 1949, that I last saw the deceased alive on 4/20, 1949, and that death occurred at 2.45 P m. 4/21/1949 from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank T. Hartleb	MD	59 E. Main St. Frostburg Md.	4/21/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	4-24-1949	Allegany	Frostburg Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-22-49	Mrs. Hally H. Roe	Jacob Wafer	Frostburg, Md

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Within corporate limits

03389

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 45 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 211 Bedford Street

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 211 Bedford Street

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) A. (Last) Willingham
4. DATE OF DEATH: (Month) April (Day) 18 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: August 24 1880
9. AGE last birthday: 68 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Baltimore & Ohio RR
11. BIRTHPLACE (State or foreign country): Duffields, W. Va.
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: John Willingham
14. MOTHER'S MAIDEN NAME: Hannah O'Connor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Spanish Amer. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-09-9807
17. INFORMANT: Mrs. John N. Miller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Terminal cardiac failure.

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary heart disease. — Since 1940

(c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: No operation
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1946, to April 17, 1949, that I last saw the deceased alive on April 17, 1949, and that death occurred at 10 P.m., from the causes and on the date stated above.

SIGNATURE: W. Alfred Van Orme — (Degree or title): M.D. — ADDRESS: 531 Louisiana Ave. Cumberland, Md. — DATE SIGNED: 4/19/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: April 21 1949 — NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park — LOCATION (City, town, or county): Cumberland, (State): Maryland

DATE REC'D BY LOCAL REG.: April 21, 1949 — REGISTRAR'S SIGNATURE: Winter L. Frantz, M.D.
24. FUNERAL DIRECTOR: William H. Kight, — ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 26 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

03390

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland; LENGTH OF STAY (In this place) 9½ Hrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland; STREET ADDRESS (If rural, give location) 750 Maryland ave.

3. NAME OF DECEASED (Type or Print): (First) Albertha (Middle) (Bertie) (Last) Wolverton

4. DATE OF DEATH: (Month) Apr. (Day) 29 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: 2-22-1874

9. AGE last birthday: 75 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Jacey Springs Va

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wm A. Long

14. MOTHER'S MAIDEN NAME: Ada Jacobs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Benjamin Ryan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	1 day
443 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 186a	(b) Hypertensive cardiovascular disease	years
	(c) ~~Fracture left humerus~~	~~4 wks~~

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture left humerus — 4 wks

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 4, 1949, to April 29, 1949, that I last saw the deceased alive on April 29, 1949, and that death occurred at 2:45 P. m., from the causes and on the date stated above.

SIGNATURE John A. Dye, M.D. (Degree or title) ADDRESS 247 Virginia Ave Cumberland, Md DATE SIGNED 4/30/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-2-1949	Zion Memorial	Cumberland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 1, 1949	Winter K. Frantz, M.D.	Charles L. George	Cumberland Md.

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Within corporate limits DR. DYER
Evidence for addition
of #18-part 1 shown on: (3)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03391

CERTIFICATE OF DEATH

Reg. Dist. No. 4

FILM No. G 120 MAY 24 1949

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MARYLAND
STREET ADDRESS (If rural, give location) QUEEN CITY PAVEMENT

3. NAME OF DECEASED (Type or Print): (First) BERNARD (Middle) F. (Last) WOODS

4. DATE OF DEATH: (Month) APRIL (Day) 26 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWER, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: JUNE 20 [redacted]

9. AGE last birthday: [redacted] 67 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: PATRICK WOODS

14. MOTHER'S MAIDEN NAME: MARY [redacted] Alberta Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: 236-12-3068

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure

581.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 124 b (b) Cirrhosis of liver [5/23/49 aka]

(c)

INTERVAL BETWEEN ONSET AND DEATH: ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-24-, 1949, to 4-26-, 1949, that I last saw the deceased alive on 4-26-, 1949, and that death occurred at 3:55 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John A. Dyer, M.D. ADDRESS 247 Virginia Ave. DATE SIGNED 4/26/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: April 29, 1949
NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery
LOCATION (City, town, or county) (State): Lonaconing, Maryland

DATE REC'D BY LOCAL REG.: April 28, 1949
REGISTRAR'S SIGNATURE: Winter R. Kantz, M.D.
24. FUNERAL DIRECTOR: M. Eichhorn, Lonaconing, Maryland ADDRESS

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